

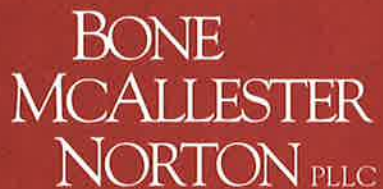
ORIGINAL

-Application

Hero

Healthcare, LLC

CN1504-012



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April 10, 2015

Via Hand Delivery

Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

RE: Application for Certificate of Need- Hero Healthcare LLC(the "Application")

Gentlemen and Ladies:

Please find the enclosed three (3) originals of the Application for filing with the Tennessee Health Services and Development Agency and the filling fee of \$3000. Please date stamp the enclosed copy of this letter and return to our courier.

If you have any questions, please contact me at (615) 238-6360.

Sincerely,

cerely,

Anne Sumpter Arney

Anne Sumpter Arney

Enclosures



State of Tennessee

Health Services and Development Agency

Andrew Jackson Building 500 Deaderick Street, 9th floor

Nashville, TN 37243

www.tn.gov/hsda

Phone: 615-741-2364

Fax: 615-741-9884

INSTRUCTIONS FOR FILING AN APPLICATION FOR A CERTIFICATE OF NEED

Please read the following instructions, the Rules and Regulations of the Agency, and Tennessee Code Annotated, §68-11-1601 *et seq.*, prior to preparation of this application.

DOCUMENTATION: In preparing this application, it is the applicant's responsibility to demonstrate through its answers that the project is necessary to provide needed health care in the area to be served, that it can be economically accomplished and maintained, and that it will contribute to the orderly development of adequate and effective health care facilities and/or services in this area. Consult Tennessee Code Annotated, §68-11-1601 *et seq.*, Health Services and Development Agency Rule 0720-4-.01, and the criteria and standards for certificate of need document Tennessee's Health: Guidelines for Growth, for the criteria for consideration for approval. Tennessee's Health: Guidelines for Growth is available from the Tennessee Health Services and Development Agency or from the Agency's website at www.tennessee.gov/HSDA. Picture of the Present is a document, which provides demographic, vital, and other statistics by county available from the Tennessee Department of Health, Bureau of Policy, Planning, and Assessment, Division of Health Statistics and can be accessed from the Department's website at www2.state.tn.us/health/statistics/HealthData/pubs_title.htm.

Please note that all applications must be submitted in triplicate (1 original and 2 copies) on single-sided, unbound letter size (8 x 11 ½) paper, and not be stapled nor have holes punched. Cover letter should also be in triplicate. If not in compliance as requested, application may be returned or reviewing process delayed until corrected pages are submitted.

REVIEW CYCLES: A review cycle is no more than sixty (60) days. The review cycle begins on the first day of each month.

COMMUNICATIONS: All documents for filing an application for Certificate of Need with the Health Services and Development Agency must be received during normal business hours (8:00a.m. - 4:30p.m. Central Time) at the Agency office, located at the Andrew Jackson Building, 9th Floor, 502 Deaderick Street, Nashville, TN 37243. For the purpose of filing Letters of Intent, application forms, and responses to supplemental information, the filing date is the actual date of receipt in the Agency office. These documents, as well as other required documents must be received as original, signed documents in the Agency office. Fax and e-mail transmissions will not be considered to be properly filed documentation. In the event that the last appropriate filing date falls on a Saturday, Sunday, or legal holiday, such filing should occur on the preceding business day. All documents are to be filed with the Agency in **single-sided and in triplicate**.

LETTER OF INTENT: Applications shall be commenced by the filing of a Letter of Intent. The Letter of Intent must be filed with the Agency between the first day and the tenth day of the month prior to the beginning of the review cycle in which the application is to be considered. This allowable filing period is inclusive of both the first day and the tenth day of the month involved. The Letter of Intent must be filed in the form and format as set forth in the application packet.

Any Letter of Intent that fails to include all information requested in the Letter of Intent form, or is not timely filed, will be deemed void, and the applicant will be notified in writing. The Letter of Intent may be refiled but, if refiled, is subject to the same requirements as set out above.

PUBLICATION OF INTENT: Simultaneously with the filing of the Letter of Intent, the Publication of Intent should be published for one day in a newspaper of general circulation in the proposed service area of the project. The Publication of Intent must be in the form and format as set forth in the application packet. The Publication of Intent should be placed in the Legal Section in a space no smaller than four (4) column inches. Publication must occur between the first day and the tenth day of the month, inclusive.

1. A "newspaper of general circulation" means a publication regularly issued at least as frequently as once a week, having a second-class mailing privilege, includes a Legal Notice Section, being not fewer than four (4) pages, published continuously during the immediately preceding one-year period, which is published for the dissemination of news of general interest, and is circulated generally in the county in which it is published and in which notice is given.
2. In any county where a "newspaper of general circulation" does not exist, the Agency's Executive Director is authorized to determine the appropriate publication to receive any required Letter of Intent. A newspaper which is engaged in the distribution of news of interest to a particular interest group or other limited group of citizens, is not a "newspaper of general circulation."
3. In the case of an application for or by a home care organization, the Letter of Intent must be published in each county in which the agency will be licensed or in a regional newspaper which qualifies as a newspaper of general circulation in each county. In those cases where the Publication of Intent is published in more than one newspaper, the earliest date of publication shall be the date of publication for the purpose of determining simultaneous review deadlines and filing the application.

PROOF OF PUBLICATION: Documentation of publication must be filed with the application form. Please submit proof of publication with the application by attaching either the full page of the newspaper in which the notice appeared, with the ***mast and dateline intact***, or a publication affidavit from the newspaper.

SIMULTANEOUS REVIEW: Those persons desiring a simultaneous review, for a Certificate of Need for which a Letter of Intent has been filed should file a Letter of Intent with the Agency and the original applicant (as well as any other applicant filing a simultaneous review), and should publish the Letter of Intent simultaneously in a newspaper of general circulation in the same county as the original applicant. The publication of the Letter of Intent by the applicant seeking simultaneous review must be published within ten (10) days after publication by the original applicant.

1. Only those applications filed in accordance with the rules of the Health Services and Development Agency, and upon consideration of the following factors as compared with the proposed project of the original applicant, may be regarded as applications filing for simultaneous review.
 - (A) Similarity of primary service area;
 - (B) Similarity of location;
 - (C) Similarity of facilities; and
 - (D) Similarity of service to be provided.

2. The Executive Director or his/her designee will determine whether applications are to be reviewed simultaneously, pursuant to Agency Rule 0720-3-.03(3).
3. If two (2) or more applications are requesting simultaneous review in accordance with the statute and rules and regulations of the Agency, and one or more of those applications is not deemed complete to enter the review cycle requested, the other application(s) that is/are deemed complete shall enter the review cycle. The application(s) that is/are not deemed complete to enter the review cycle will not be considered as competing with the application(s) deemed complete and entering the review cycle.

FILING THE APPLICATION: *All applications*, including applications requesting simultaneous review, must be filed in ***triplicate*** (original and two (2) copies) with the Agency within five (5) days after publication of the Letter of Intent. ***The date of filing is the actual date of receipt at the Agency office.***

Applications should have all pages numbered.

All attachments should be attached to the back of the application, be identified by the applicable item number of the application, and placed in alpha-numeric order consistent with the application form. For example, an Option to Lease a building should be identified as Attachment A.6., and placed before Financial Statements which should be identified as Attachment C. Economic Feasibility.10. The last page of an application should be the completed affidavit.

Failure by the applicant to file an application within five (5) days after publication of the Letter of Intent shall render the Letter of Intent, and hence the application, ***void***.

FILING FEE: The amount of the initial filing fee shall be an amount equal to \$2.25 per \$1,000 of the estimated project cost involved, but in no case shall the fee be less than \$3,000 or more than \$45,000. Checks should be made payable to the Health Services and Development Agency.

FILING FEES ARE NON-REFUNDABLE and must be received by the Agency before review of the application will begin.

REVIEW OF APPLICATIONS FOR COMPLETENESS: When the application is received at the Agency office, it will be reviewed for completeness. The application must be consistent with the information given in the Letter of Intent in terms of both project scope and project cost. ***Review for completeness will not begin prior to the receipt of the filing fee.***

1. If the application is deemed complete, the Agency will acknowledge receipt and notify the applicant as to when the review cycle will begin. "Deeming complete" means that all questions in the application have been answered and all appropriate documentation has been submitted in such a manner that the Health Services and Development Agency can understand the intent and supporting factors of the application. Deeming complete shall not be construed as validating the sufficiency of the information provided for the purposes of addressing the criteria under the applicable statutes, the Rules of the Health Services and Development Agency, or the standards set forth in the State Health Plan/Guidelines for Growth.
2. If the application is incomplete, requests by Agency staff for supplemental information must be completed by the applicant within sixty (60) days of the written request. Please note that supplemental information must be submitted timely for the application to be deemed complete prior to the beginning date of the review cycle which the applicant intends to enter, even if that time is less than the sixty (60) days which is allowed by the statute. If the requested information is submitted within sixty (60) days of the request, but not by the date specified in the staff's letter, the application is not void, but will enter the ***next*** review cycle. If an application is not deemed complete within sixty (60) days after the written

notification is given by the Agency staff that the application is deemed incomplete, the application shall be deemed void. If the applicant decides to re-submit the application, the applicant shall comply with all procedures as set out by this part and a new filing fee shall accompany the refiled application.

Each supplemental question and its corresponding response shall be typed and submitted on a separate sheet of 8 1/2" x 11" paper, be filed in **triplicate**, and include a signed affidavit. All requested supplemental information must be received by the Agency to allow staff sufficient time for review before the beginning of the review cycle in order to enter that review cycle.

3. Applications for a Certificate of Need, including competing applications, will not be considered unless filed with the Agency within such time as to assure such application is deemed complete.

All supplemental information shall be submitted simultaneously and only at the request of staff, with the only exception being letters of support and/or opposition.

The Agency will promptly forward a copy of each complete application to the Department of Health or the Department of Mental Health and Developmental Disabilities for review. The Department reviewing the application may contact the applicant to request additional information regarding the application. The applicant should respond to any reasonable request for additional information promptly.

AMENDMENTS OR CHANGES IN AN APPLICATION: An application for a Certificate of Need which has been deemed complete **CANNOT** be amended in a substantive way by the applicant during the review cycle. Clerical errors resulting in no substantive change may be corrected.

- * **WITHDRAWAL OF APPLICATIONS:** The applicant may withdraw an application at any time by providing written notification to the Agency.
- * **TIMETABLE FOR CERTIFICATE OF NEED EXPIRATION:** The Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; *however*, the Agency may extend a Certificate of Need for a reasonable period upon application and good cause shown, accompanied by a non-refundable filing fee, as prescribed by Rules. An extension cannot be issued to any applicant unless substantial progress has been demonstrated. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.
- * **For further information concerning the Certificate of Need process, please call the offices of the Health Services and Development Agency at 615/741-2364.**
- * **For information concerning the Joint Annual Reports of Hospitals, Nursing Homes, Home Care Organizations, or Ambulatory Surgical Treatment Centers, call the Tennessee Department of Health, Office of Health Statistics and Research at 615/741-1954**
- * **For information concerning Guidelines for Growth call the Health Services and Development Agency at 615/741-2364. For information concerning Picture of the Present call the Department of Health, Office of Health Statistics at 615/741-9395.**
- * **For information concerning mental health and developmental disabilities applications call the Tennessee Department of Mental Health and Developmental Disabilities, Office of Policy and Planning at 615/532-6500.**

SECTION A:

APPLICANT PROFILE

Please enter all Section A responses on this form. All questions must be answered. If an item does not apply, please indicate "N/A". **Attach appropriate documentation as an Appendix at the end of the application and reference the applicable Item Number on the attachment.**

For Section A, Item 1, Facility Namemust be applicant facility's name and addressmust be the site of the proposed project.

For Section A, Item 3, Attach a copy of the partnership agreement, or corporate charter **and** certificate of corporate existence, if applicable, from the Tennessee Secretary of State.

For Section A, Item 4, Describe the existing or proposed ownership structure of the applicant, including an ownership structure organizational chart. Explain the corporate structure and the manner in which all entities of the ownership structure relate to the applicant. As applicable, identify the members of the ownership entity and each member's percentage of ownership, for those members with 5% or more ownership interest. In addition, please document the financial interest of the applicant, and the applicant's parent company/owner in any other health care institution as defined in Tennessee Code Annotated, §68-11-1602 in Tennessee. At a minimum, please provide the name, address, current status of licensure/certification, and percentage of ownership for each health care institution identified.

For Section A, Item 5, For new facilities or existing facilities without a current management agreement, attach a copy of a draft management agreement that at least includes the anticipated scope of management services to be provided, the anticipated term of the agreement, and the anticipated management fee payment methodology and schedule. For facilities with existing management agreements, attach a copy of the fully executed final contract.

Please describe the management entity's experience in providing management services for the type of the facility, which is the same or similar to the applicant facility. Please describe the ownership structure of the management entity.

For Section A, Item 6, For applicants or applicant's parent company/owner that currently own the building/land for the project location; attach a copy of the title/deed. For applicants or applicant's parent company/owner that currently lease the building/land for the project location, attach a copy of the fully executed lease agreement. For projects where the location of the project has not been secured, attach a fully executed document including Option to Purchase Agreement, Option to Lease Agreement, or other appropriate documentation. Option to Purchase Agreements **must include** anticipated purchase price. Lease/Option to Lease Agreements **must include** the actual/anticipated term of the agreement **and** actual/anticipated lease expense. The legal interests described herein **must be valid** on the date of the Agency's consideration of the certificate of need application.

1. **Name of Facility, Agency, or Institution**

Hero Healthcare, LLC
 Name
 231 Walls Hollow Road Morgan
 Street or Route County
 Oliver Springs TN 37840
 City State Zip Code

2. **Contact Person Available for Responses to Questions**

Anne Sumpter Arney Attorney
 Name Title
 Bone McAllester Norton PLLC asarney@bonelaw.com
 Company Name Email address
 511 Union Street, Suite 1600 Nashville TN 37219
 Street or Route City State Zip Code
 Counsel 615-238-6360 615-687-2764
 Association with Owner Phone Number Fax Number

3. **Owner of the Facility, Agency or Institution**

Hero Healthcare, LLC 423-627-7626
 Name Phone Number
 231 Walls Hollow Road Morgan
 Street or Route County
 Oliver Springs TN 37840
 City State Zip Code

4. **Type of Ownership of Control (Check One)**

- | | | | |
|---------------------------------|-------|--|----------|
| A. Sole Proprietorship | _____ | F. Government (State of TN or Political Subdivision) | _____ |
| B. Partnership | _____ | G. Joint Venture | _____ |
| C. Limited Partnership | _____ | H. Limited Liability Company | <u>x</u> |
| D. Corporation (For Profit) | _____ | Sharlyn Young is the sole member | |
| E. Corporation (Not-for-Profit) | _____ | I. Other (Specify) _____ | |

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

5. **Name of Management/Operating Entity(If Applicable)**

N/A

Name _____

Street or Route _____

County _____

City _____

State _____

Zip Code _____

**PUT ALL ATTACHMENTS AT THE END OF THE APPLICATION IN ORDER AND
REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.**

6. **Legal Interest in the Site of the Institution(Check One)**

A. Ownership _____

B. Option to Purchase _____

C. Lease of 5 Years X

D. Option to Lease _____

E. Other (Specify) _____

**PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND
REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.**

7. **Type of Institution(Check as appropriate--more than one response may apply)**

A. Hospital (Specify) _____

B. Ambulatory Surgical Treatment
Center (ASTC), Multi-Specialty _____

C. ASTC, Single Specialty _____

D. Home Health Agency X

E. Hospice _____

F. Mental Health Hospital _____

G. Mental Health Residential
Treatment Facility _____

H. Mental Retardation Institutional
Habilitation Facility (ICF/MR) _____

I. Nursing Home _____

J. Outpatient Diagnostic Center _____

K. Recuperation Center _____

L. Rehabilitation Facility _____

M. Residential Hospice _____

N. Non-Residential Methadone
Facility _____

O. Birthing Center _____

P. Other Outpatient Facility
(Specify) _____

Q. Other (Specify) _____

8. **Purpose of Review(Check) as appropriate--more than one response may apply)**

A. New Institution X

B. Replacement/Existing Facility _____

C. Modification/Existing Facility _____

D. Initiation of Health Care
Service as defined in TCA §
68-11-1607(4)
(Specify) _____

E. Discontinuance of OB Services _____

F. Acquisition of Equipment _____

G. Change in Bed Complement
[Please note the type of change
by underlining the appropriate
response: Increase, Decrease,
Designation, Distribution,
Conversion, Relocation]

H. Change of Location _____

I. Other (Specify) _____

9. **Bed Complement Data** N/A

Please indicate current and proposed distribution and certification of facility beds.

	<u>Current Beds Licensed *CON</u>	<u>Staffed Beds</u>	<u>Beds Proposed</u>	<u>TOTAL Beds at Completion</u>
A. Medical	_____	_____	_____	_____
B. Surgical	_____	_____	_____	_____
C. Long-Term Care Hospital	_____	_____	_____	_____
D. Obstetrical	_____	_____	_____	_____
E. ICU/CCU	_____	_____	_____	_____
F. Neonatal	_____	_____	_____	_____
G. Pediatric	_____	_____	_____	_____
H. Adult Psychiatric	_____	_____	_____	_____
I. Geriatric Psychiatric	_____	_____	_____	_____
J. Child/Adolescent Psychiatric	_____	_____	_____	_____
K. Rehabilitation	_____	_____	_____	_____
L. Nursing Facility (non-Medicaid Certified)	_____	_____	_____	_____
M. Nursing Facility Level 1 (Medicaid only)	_____	_____	_____	_____
N. Nursing Facility Level 2 (Medicare only)	_____	_____	_____	_____
O. Nursing Facility Level 2 (dually certified Medicaid/Medicare)	_____	_____	_____	_____
P. ICF/MR	_____	_____	_____	_____
Q. Adult Chemical Dependency	_____	_____	_____	_____
R. Child and Adolescent Chemical Dependency	_____	_____	_____	_____
S. Swing Beds	_____	_____	_____	_____
T. Mental Health Residential Treatment	_____	_____	_____	_____
U. Residential Hospice	_____	_____	_____	_____

TOTAL

*CON-Beds approved but not yet in service

10. **Medicare Provider Number**
Certification Type

N/A

11. **Medicaid Provider Number**
Certification Type

N/A

12. **If this is a new facility, will certification be sought for Medicare and/or Medicaid?** No.

13. **Identify all TennCare Managed Care Organizations/Behavioral Health Organizations (MCOs/BHOs) operating in the proposed service area. Will this project involve the treatment of TennCare participants?** No. **If the response to this item is yes, please identify all MCOs/BHOs with which the applicant has contracted or plans to contract.**

NOTE: **Section B** is intended to give the applicant an opportunity to describe the project and to discuss the need that the applicant sees for the project. **Section C** addresses how the project relates to the Certificate of Need criteria of Need, Economic Feasibility, and the Contribution to the Orderly Development of Health Care. **Discussions on how the application relates to the criteria should not take place in this section unless otherwise specified.**

SECTION B: PROJECT DESCRIPTION

I. Provide a brief executive summary of the project not to exceed two pages. Topics to be included in the executive summary are a brief description of proposed services and equipment, ownership structure, service area, need, existing resources, project cost, funding, financial feasibility and staffing.

Response: Executive Summary of Project

Proposed Services

Hero Healthcare, LLC ("Hero" or "Applicant") seeks a certificate of need ("CON") for home health services restricted to the care of one fragile elderly resident of Anderson County. ("Patient X"). Patient X is a beneficiary of the United States Department of Labor, Division of Energy Employees Occupation Illness Compensation Program ("EEOICP"). The Energy Employees Occupation Illness Compensation Program was established by Congress to provide compensation and medical benefits to individual who were employed by the Department of Energy ("DOE") and its predecessor agencies who are suffering from illnesses incurred in the performance of their duties for the DOE. Hero is an authorized provider under EEOICP. All compensation for services to Patient X will be paid through Applicant's provider agreement with the DOE. Hero has been providing care to Patient X since September of 2014. Hero is authorized by EEOICP to provide contract nurse services which include but are not limited to the following: 24/7 Skilled nursing care, oxygen therapy, medication administration, and colostomy care and case management by registered nurse. Ms. Young, the sole member of the Applicant, supervises all of Hero's services and is on site with Patient X over 60 hours a week. Although the Applicant provides and seeks to provide services to only one patient, it has been advised by the Tennessee Department of Health that it must seek a license as a home health agency.

Equipment

No medical equipment will be purchased by the Applicant for use in the project.

Ownership

Hero is a Tennessee limited liability company which is wholly owned by Sharlyn Young a Tennessee licensed practical nurse. Ms. Young organized Hero for the sole purpose of providing care to Patient X. Ms. Young supervises all of Hero's services and is on site with Patient X over 60 hours a week.

Service Area

The Applicant seeks a CON to be licensed in both Morgan and Anderson counties because Applicant's business address is in Morgan County; however, the services will be limited to Patient X's address in Anderson County. No services will be provided in Morgan County.

Need and Existing Resources

Through the EEOICP, Congress recognized the need to provide care to former DOE employees such as Patient X through a program that allows them to receive 24/7 nursing care without seeking payment from other federal and state health care programs and with no out of pocket expense to the beneficiary. The DOE has eight active worksites in Oak Ridge, Roane County, Tennessee. Many of the EEOICP beneficiaries are former employees of these sites and live in the areas of Tennessee near Oak Ridge. As a result, the Applicant believes that the need to provide the comprehensive services that are a benefit of EEOICP is greater than other areas of Tennessee. The Applicant's proposed principal service area of Anderson County is adjacent to Roane County and although in 2014, there were 21 other home health agencies who reported serving patients in Anderson County and 21 in Morgan County, to the Applicant's knowledge only 11 of them are contracted to provide services under EEOICP in Anderson County and 8 of them are EEOICP providers in Morgan County. EEOICP provides an important and earned benefit to former federal energy employees and contractors. There is a need for home health agencies that can provide all of the services required by the EEOICP beneficiaries.

Hero has been caring for Patient X as an EEOICP contract nurse and although the Applicant has only one patient, it has been advised by the Department of Health that in order to continue to provide the EEOICP contracted services Hero must obtain a CON and become a licensed home care organization. The care provided by Hero is substantially different from the most home health agencies because its services are comprehensive and include both nursing and home maker services. As a result, Hero is able to provide Patient X all of his required care in his home. Patient X has limited family support and the level of services provided by the Applicant could not be provided by an agency which was not dedicated to the care of single patient. Because the Applicant serves only Patient X, it is able to provide a level of 24/7 care in his home that is necessary for his chronic long term nursing needs. A change in his care at the end of his life will not be in the best interest of his physical or mental health. Patient X's primary care provider has submitted a letter in support of this Application. It is the Applicant's position that the services are not only needed but essential to Patient X as an EEOICP beneficiary. In addition, if Hero is granted a CON, there will be no negative competitive impact on existing resources because the services will be limited to one patient and therefore, limited to the duration of his life. If granted CON approval, Hero is immediately able to provide 24 hour care to Patient X.

Project Costs, Funding and Financial Feasibility

The only cost associated with this project is \$28,000 which is the cost incurred in preparing and filing this Application. The project costs will be funded from the cash reserves of the Applicant. The project cost is reasonable and will not require any capital expenditures.

Staffing

In addition to Ms. Young who is not paid a salary but is compensated as the owner of Hero, the Applicant has 3 FTE and 1 part time employee. All of whom are LPNs and work in 12 hour shifts. In addition, Hero contracts with a registered nurse to provide services for 4 hours a month.

- II. Provide a detailed narrative of the project by addressing the following items as they relate to the proposal.
 - A. Describe the construction, modification and/or renovation of the facility (exclusive of major medical equipment covered by T.C.A. § 68-11-1601 et seq.) including square footage, major operational areas, room configuration, etc. Applicants with hospital

projects (construction cost in excess of \$5 million) and other facility projects (construction cost in excess of \$2 million) should complete the Square Footage and Cost per Square Footage Chart. Utilizing the attached Chart, applicants with hospital projects should complete Parts A.-E. by identifying as applicable nursing units, ancillary areas, and support areas affected by this project. Provide the location of the unit/service within the existing facility along with current square footage, where, if any, the unit/service will relocate temporarily during construction and renovation, and then the location of the unit/service with proposed square footage. The total cost per square foot should provide a breakout between new construction and renovation cost per square foot. Other facility projects need only complete Parts B.-E. Please also discuss and justify the cost per square foot for this project.

If the project involves none of the above, describe the development of the proposal.

Response: The Applicant seeks a CON to provide home health services restricted to a single elderly patient who is a beneficiary under EEOICP. Patient X suffers from an occupational related illness and requires 24/7 nursing care. Patient X sought out the Applicant and asked Hero to provide his care. The Applicant was organized solely to meet the long term comprehensive nursing needs of Patient X. Although the Applicant's services are limited to one patient, Hero has been advised by the Tennessee Department of Health that in order to continue to provide services to Patient X, it must seek and obtain a CON and become a licensed home care organization. If granted a CON, Hero would continue to limit its services to Patient X. Hero has not and does not seek to provide services to any other individual. The Applicant does not intend to become enrolled in Medicare or TennCare. All payment for the Applicant's services will be from EEOICP.

- B. Identify the number and type of beds increased, decreased, converted, relocated, designated, and/or redistributed by this application. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the existing services.

Response: Not applicable.

C. As the applicant, describe your need to provide the following health care services (if applicable to this application):

1. Adult Psychiatric Services
2. Alcohol and Drug Treatment for Adolescents (exceeding 28 days)
3. Birthing Center
4. Burn Units
5. Cardiac Catheterization Services
6. Child and Adolescent Psychiatric Services
7. Extracorporeal Lithotripsy
8. **Home Health Services x**
9. Hospice Services
10. Residential Hospice
11. ICF/MR Services
12. Long-term Care Services
13. Magnetic Resonance Imaging (MRI)
14. Mental Health Residential Treatment
15. Neonatal Intensive Care Unit
16. Non-Residential Methadone Treatment Centers
17. Open Heart Surgery
18. Positron Emission Tomography
19. Radiation Therapy/Linear Accelerator
20. Rehabilitation Services
21. Swing Beds

Response: The Applicant seeks a CON to provide Home Health Services limited to a single recipient of EEOICP benefits. The Applicant is an authorized provider under EEOICP and has been providing nursing care to Patient X. Although the Applicant provides care to only one patient and has represented that it will not expand to any other individual, it has been advised by the Department of Health that it must be licensed as a home health agency. Therefore, Hero is seeking a CON in order to obtain a license as a home health agency in order to continue to provide the care to Patient X for the duration of his life. Patient X suffers from several progressive and debilitating diseases as a result of his former employment and exposure to toxic substances. Hero provides his care as a qualified EEOICP provider and does not see any other patients. Hero is able to provide the care authorized by his physician and EEOICP. Hero's services allow Patient X to continue to live independently in the comfort of his own home despite the need for comprehensive 24/7 care..

D. Describe the need to change location or replace an existing facility.

Response: Not applicable.

E. Describe the acquisition of any item of major medical equipment (as defined by the Agency Rules and the Statute) which exceeds a cost of \$1.5 million; and/or is a magnetic resonance imaging (MRI) scanner, positron emission tomography (PET) scanner, extracorporeal lithotripter and/or linear accelerator by responding to the following:

1. For fixed-site major medical equipment (not replacing existing equipment):
 - a. Describe the new equipment, including:
 1. Total cost (As defined by Agency Rule);
 2. Expected useful life;
 3. List of clinical applications to be provided; and

4. Documentation of FDA approval.
- b. Provide current and proposed schedules of operations.
2. For mobile major medical equipment:
 - a. List all sites that will be served;
 - b. Provide current and/or proposed schedule of operations;
 - c. Provide the lease or contract cost.
 - d. Provide the fair market value of the equipment;
 - and e. List the owner for the equipment.
3. Indicate applicant's legal interest in equipment (*i.e.*, purchase, lease, etc.). In the case of equipment purchase include a quote and/or proposal from an equipment vendor, or in the case of an equipment lease provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments.

Response: Not Applicable

III. (A) Attach a copy of the plot plan of the site on an 8 1/2" x 11" sheet of white paper which **must** include:

1. Size of site (*in acres*);
2. Location of structure on the site; and
3. Location of the proposed construction.
4. Names of streets, roads or highway that cross or border the site.

Please note that the drawings do not need to be drawn to scale. Plot plans are required for all projects.

- (B)** 1. Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients.

Response: Not Applicable

- IV.** Attach a floor plan drawing for the facility which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc. on an 8 1/2" x 11" sheet of white paper.

NOTE: **DO NOT SUBMIT BLUEPRINTS**. Simple line drawings should be submitted and need not be drawn to scale.

Response: Not Applicable

- V.** For a Home Health Agency or Hospice, identify:

1. Existing service area by County;

Response: NA

2. Proposed service area by County;

Response: Anderson and Morgan

3. A parent or primary service provider;

Response: Not Applicable

4. Existing branches; and

Response: Not Applicable

5. Proposed branches.

Response: Not Applicable

SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED

In accordance with Tennessee Code Annotated § 68-11-1609(b), "no Certificate of Need shall be granted unless the action proposed in the application for such Certificate is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, and will contribute to the orderly development of health care." The three (3) criteria are further defined in Agency Rule 0720-4-.01. Further standards for guidance are provided in the state health plan (Guidelines for Growth), developed pursuant to Tennessee Code Annotated §68-11-1625.

The following questions are listed according to the three (3) criteria: (I) Need, (II) Economic Feasibility, and (III) Contribution to the Orderly Development of Health Care. Please respond to each question and provide underlying assumptions, data sources, and methodologies when appropriate. Please type each question and its response on an 8 1/2" x 11" white paper. All exhibits and tables must be attached to the end of the application in correct sequence identifying the question(s) to which they refer. If a question does not apply to your project, indicate "Not Applicable (NA)."

QUESTIONS

NEED

1. Describe the relationship of this proposal toward the implementation of the State Health Plan and Tennessee's Health: Guidelines for Growth.
 - a. Please provide a response to each criterion and standard in Certificate of Need Categories that are applicable to the proposed project. Do not provide responses to General Criteria and Standards (pages 6-9) here.
 - b. Applications that include a Change of Site for a health care institution, provide a response to General Criterion and Standards (4)(a-c)

Response:

Implementation of the State Health Plan.

(1). The purpose of the State Health Plan is to improve the health of Tennesseans.

Patient X is a fragile elderly patient living in his home with little family assistance. He is

dependent on the individually focused care that the Applicant provides. Because its services are limited to one patient, Hero is able to provide Patient X the level of care that is typically provided only with the dedicated assistance and supervision of family members. Hero seeks to continue to provide the customized care that Patient X requires and which is not available through other home health agencies or skilled nursing facilities in Anderson County. The continued 24/7 care in his home by the Applicant's skilled nurses and care givers is in the best interest of Patient X's health and consistent with the principals of patient centered care. Letters of support from Patient X and his family are at Attachment C Need 1 (1).

(2) Every citizen should have reasonable access to health care.

If the Applicant is not granted a CON, it is unlikely that Patient X will continue to have access to the necessary care in his home. Patient X is ill and without family available to assist and supervise his care. Hero provides Patient X access to a level of care that he could not obtain with other providers. Ms. Young, as the owner of Hero, provides supervision of all services in the home for more than 60 hours a week in order to insure that Patient X has all of the nursing care he requires.

(3) The State's health care resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies, and the continued development of the State's health care system.

The health of Tennesseans is improved if there is an opportunity for their needs to be met by specific solutions that do not disrupt the orderly development of health care. In addition, Hero provides care in the most efficient method by having very limited administrative services so that the cost of comprehensive care can be provided in an extremely economically efficient manner. In addition, Hero is a woman-owned Tennessee small business which is located in a rural county. Its business is consistent with the development of individualized health care solutions to better meet the health care needs of Tennessee and to provide economic opportunities to Tennessee owned small businesses. A letter of support from Morgan County Executive is Attachment C Need 1 (3). Although the Applicant will not be the only holder of a Certificate of Need in Morgan County as mistakenly stated in the letter, the letter shows local government's support for the Application.

(4) Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers.

All of Hero's employees and contractors are licensed by the Tennessee Board of Nursing and monitored and required to adhere to the Board of Nursing's rules and standards. In addition, if it is able to be licensed as a home care organization it will be monitored by the Tennessee Department of Health Facilities.

(5) The state should support the development, recruitment, and retention of a sufficient and quality health care workforce.

Hero is a Tennessee small business owned by a citizen of Tennessee who employs other Tennesseans who are skilled health care providers in and around Anderson and Morgan counties. According to the statistics of Tennessee Advisory Commission on Intergovernmental Relations, in 2013 Anderson and Morgan Counties had

unemployment rates of 9.3 and 7.3 respectively.

Guidelines for Growth.

1. The need for home health agencies/services shall be determined on a county by county basis.
2. In a given county, 1.5 percent of the total population will be considered as the need estimate for home health services in that county. The 1.5 percent formula will be applied as a general guideline, as a means of comparison within the proposed service area.
3. Using recognized population sources, projections for four years into the future will be used.
4. The use rate of existing home health agencies in the county will be determined by examining the latest utilization rate as calculated in the Joint Annual Report of existing home health agencies in the service area. Based on the number of patients served by home health agencies in the service area, estimation will be made as to how many patients could be served in the future.

Using the information in the 2013 Home Health Agency Joint Annual Reports, the Office of Health Statistics in Tennessee Department of Health projected that the need for home health services in Anderson County would be 1,168 patients in 2018 with a projected surplus capacity of 1,789. According to University of Tennessee Center for Business and Economic Research Population Projection Data (2013 Revision) for 2010-2020, the projected population growth for Anderson County would be 77,273 in 2016, 77,582 in 2017, 77,851 in 2018 and 78,123 in 2019. The Applicant will not provide services in Morgan County so the need in Morgan County will not be affected by the Applicant, however, the Applicant provides the following information for the purpose of completion of this Application: Using the 2013 Home Health Agency Joint Annual Reports, the Office of Health Statistics in Tennessee Department of Health projected that the need for home health services in Morgan County would be 330 patients in 2018 with a projected surplus capacity of 146. According to University of Tennessee Center for Business and Economic Research Population Projection Data (2013 Revision), for 2010-2020, the projected population for Morgan County would be 31,297 in 2016, 31,247 in 2017, 31,222 in 2018 and 31,218 in 2019.

The Applicant does not believe this question is applicable since the need for Hero to obtain a license as a Home Health Agency is specific to Patient X and will not affect the need or surplus of care in the Service Area. Hero has been providing care to Patient X and in order to continue to deliver the level of care required by Patient X, Hero has been advised by the Tennessee Department of Health that it must be licensed as a home health agency. Because Hero seeks a limited license restricted to the care of Patient X, Hero's services will not have a significant impact on home health need or capacity in Anderson County and Hero will not provide services in Morgan County.

2. Describe the relationship of this project to the applicant facility's long-range development plans, if any.

Response: Not applicable. Hero has no long range development plan other than to provide care to Patient X to the end of his life.

3. Identify the proposed service area and justify the reasonableness of that proposed area. Submit a county level map including the State of Tennessee clearly marked to reflect the service area. **Please submit the map on 8 1/2" x 11" sheet of white paper marked only with ink detectable by a standard photocopier (i.e., no highlighters, pencils, etc.).**

Response: Please see a map of the proposed service area included as Attachment C Need 3.

4. A. Describe the demographics of the population to be served by this proposal.

Response: Please see chart included as Attachment C Need 4 A which sets forth the current population and the 2018 projected population for Anderson County and Morgan County. Hero will only serve Patient X who is frail elderly man living alone.

- B. Describe the special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.

Response: According to the projected 2014 data set forth in the Tennessee Department of Health's Population Projections June 2013, US Census Quickfacts set forth in Chart 1 at Attachment C Need 4, the Age 65+ population of Anderson County is 18.98% which is a higher percentage of Age 65+ than projected for Tennessee as a whole with 17.7% of the county's population living below the poverty line. In addition, according to the 2010 Census, the projected Age 65+ population for Anderson County is projected to grow to 20.9% by 2018. Hero meets the need of the growing elderly population Anderson County of by serving Patient X was is part of the aged population of Anderson County and could not afford the level of care he receives other than the EEOICP benefits. The Applicant will not provide services in Morgan County so the special needs of its population are not applicable. However, Chart 1 at Attachment C Need 4 shows that Morgan County would have substantially similar needs to Anderson County.

5. Describe the existing or certified services, including approved but unimplemented CONs, of similar institutions in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. Be certain to list each institution and its utilization and/or occupancy individually. Inpatient bed projects must include the following data: admissions or discharges, patient days, and occupancy. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc.

Response: Please see the Charts 2, 3 and 4 attached as Attachment C Need 5. Chart 2 is a list of the licensed home health agencies in the Service Area. Chart 3 shows the total utilization of these home health agencies and Chart 4 shows the services provided by these home health agencies in the Service Area by discipline. All information is based on the 2014 Joint Annual Reports. According to Chart 3, the total patients served in Anderson and Morgan County already exceeds the standard of 1.5 percent in the Guidelines for Growth. However, a number of factors support a greater need for home health agency services in Anderson and Morgan Counties than the 1.5 percent standard. First the travel time in these rural counties for home health staff is significantly greater than in more populated areas. It

simply takes more staff to serve the same number of patients. In addition, it is likely with the projected growth in the Age 65+ population that the needs in Anderson County will continue to be greater than the projected need in the Guidelines for Growth. As an adjacent county, to the location of most of the Department of Energy sites it is also an area that will likely have a higher number of EEOICP beneficiaries than other areas of Tennessee. Finally, regardless of a current or future surplus of services, the project will have minimal effect on the surplus of services because the Applicants services will be a limited to providing care to Patient X and as a result is limited in duration. Since the Applicant does not seek to provide services in Morgan County and is including Morgan County in its Service Area only because Morgan County is the business address of Hero, the project will have no effect on the need or surplus for home health services in Morgan County. However, in order to be fully responsive in this Application, the Charts included at Attachment C Need 5 also include information with respect to services in Morgan County

6. Provide applicable utilization and/or occupancy statistics for your institution for each of the past three (3) years and the projected annual utilization for each of the two (2) years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology **must include** detailed calculations or documentation from referral sources, and identification of all assumptions.

Response: Hero will have one patient and projects having one patient for the next 2 years. A letter from Coalfield Medical Clinic stating that it will refer Patient X to Hero for care is Attachment C. Need 6

ECONOMIC FEASIBILITY

1. Provide the cost of the project by completing the Project Costs Chart on the following page. Justify the cost of the project.

- All projects should have a project cost of at least \$3,000 on Line F. (Minimum CON Filing Fee). CON filing fee should be calculated from Line D. (See Application Instructions for Filing Fee)
- The cost of any lease (building, land, and/or equipment) should be based on fair market value or the total amount of the lease payments over the initial term of the lease, whichever is greater. Note: This applies to all equipment leases including by procedure or "per click" arrangements. The methodology used to determine the total lease cost for a "per click" arrangement must include, at a minimum, the projected procedures, the "per click" rate and the term of the lease.
- The cost for fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful life of the equipment; federal, state, and local taxes and other government assessments; and installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.
- For projects that include new construction, modification, and/or renovation; **documentation must be** provided from a contractor and/or architect that support the estimated construction costs.

Response: There are no costs to the project other than the legal costs associated with the application and the filing fee. These costs have either already been paid or will be paid from the cash reserves of the Applicant.

PROJECT COSTS CHART

A.	Construction and equipment acquired by purchase:	
1.	Architectural and Engineering Fees	_____
2.	Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	<u>\$25,0000</u>
3.	Acquisition of Site	_____
4.	Preparation of Site	_____
5.	Construction Costs	_____
6.	Contingency Fund	_____
7.	Fixed Equipment (Not included in Construction Contract)	_____
8.	Moveable Equipment (List all equipment over \$50,000)	_____
9.	Other (Specify) _____	_____
B.	Acquisition by gift, donation, or lease:	
1.	Facility (inclusive of building and land)	_____
2.	Building only	_____
3.	Land only	_____
4.	Equipment (Specify) _____	_____
5.	Other (Specify) _____	_____
C.	Financing Costs and Fees:	
1.	Interim Financing	_____
2.	Underwriting Costs	_____
3.	Reserve for One Year's Debt Service	_____
4.	Other (Specify) _____	_____
D.	Estimated Project Cost (A+B+C)	_____
E.	CON Filing Fee	<u>\$3000</u>
F.	Total Estimated Project Cost (D+E)	
TOTAL		\$28,000

2. Identify the funding sources for this project.

Please check the applicable item(s) below and briefly summarize how the project will be financed. (**Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment C, Economic Feasibility-2.**)

- ☐ A. Commercial loan--Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;
- ☐ B. Tax-exempt bonds--Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;
- ☐ C. General obligation bonds--Copy of resolution from issuing authority or minutes from the appropriate meeting.
- ☐ D. Grants--Notification of intent form for grant application or notice of grant award; or
- ☒ E. Cash Reserves--Appropriate documentation from the President and Sole Member.
- ☐ F. Other--Identify and document funding from all other sources.

Response: Not applicable. There are no ongoing costs for the project. The filing fee will be paid at the time the application is filed and the legal fees associated with the project are anticipated to be paid on an ongoing basis from the Applicant's cash reserves.

3. Discuss and document the reasonableness of the proposed project costs. If applicable, compare the cost per square foot of construction to similar projects recently approved by the Health Services and Development Agency.

Response: There are no proposed project costs other than those associated with the filing of the Application itself. Hero already has all of the equipment and workforce that it will require.

4. Complete Historical and Projected Data Charts on the following two pages--**Do not modify the Charts provided or submit Chart substitutions!** Historical Data Chart represents revenue and expense information for the last *three* (3) years for which complete data is available for the institution. Projected Data Chart requests information for the two (2) years following the completion of this proposal. Projected Data Chart should reflect revenue and expense projections for the **Proposal Only** (i.e., if the application is for additional beds, include anticipated revenue from the proposed beds only, not from all beds in the facility).

Response: Please see Historical and Projected Data Charts for the Applicant.

5. Please identify the project's average gross charge, average deduction from operating revenue, and average net charge.

Response: Hero's current and proposed charges are 74.30 an hour which is the current hourly rate for contract nursing care as paid by EEOICP.

HISTORICAL DATA CHART

Give information for the last *three* (3) years for which complete data are available for the facility or agency. The fiscal year begins in _____ (Month).*

	Year _____	Year _____	Year 2014
A. Utilization Data (Specify unit of measure)	_____	_____	_____
B. Revenue from Services to Patients			
1. Inpatient Services	\$ _____	\$ _____	\$ _____
2. Outpatient Services	_____	_____	_____
3. Emergency Services	_____	_____	_____
4. Other Operating Revenue – Home Health Services	_____	_____	\$ _____
Gross Operating Revenue	\$ _____	\$ _____	\$ _____
C. Deductions from Gross Operating Revenue			
1. Contractual Adjustments	\$ _____	\$ _____	\$ _____
2. Provision for Charity Care	_____	_____	_____
3. Provisions for Bad Debt	_____	_____	_____
Total Deductions	\$ _____	\$ _____	\$ _____
NET OPERATING REVENUE	\$ _____	\$ _____	\$ _____
D. Operating Expenses			
1. Salaries and Wages	\$ _____	\$ _____	\$ _____
2. Physician's Salaries and Wages	_____	_____	_____
3. Supplies	_____	_____	_____
4. Taxes	_____	_____	_____
5. Depreciation	_____	_____	_____
6. Rent	_____	_____	_____
7. Interest, other than Capital	_____	_____	_____
8. Management Fees:			
a. Fees to Affiliates	_____	_____	_____
b. Fees to Non-Affiliates	_____	_____	_____
9. Other Expenses (repairs, maintenance, insurance, contract labor, and professional fees).	_____	_____	_____
Total Operating Expenses	\$ _____	\$ _____	\$ _____
E. Other Revenue (Expenses) – Net (Specify)	\$ _____	\$ _____	\$ _____
NET OPERATING INCOME (LOSS)	\$ _____	\$ _____	\$ _____
F. Capital Expenditures			
1. Retirement of Principal	\$ _____	\$ _____	\$ _____
2. Interest	_____	_____	_____
Total Capital Expenditures	\$ _____	\$ _____	\$ _____
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	\$ _____	\$ _____	\$ _____

PROJECTED DATA CHART

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in January. (Month)

	Year 2015	Year 2016
A. Utilization Data (Specify unit of measure)	<u>Per Patient</u>	<u> </u>
B. Revenue from Services to Patients		
1. Inpatient Services	\$ <u> </u>	\$ <u> </u>
2. Outpatient Services	<u>649,084</u>	<u>649,084</u>
3. Emergency Services	<u> </u>	<u> </u>
4. Other Operating Revenue (Specify) <u> </u>	<u> </u>	<u> </u>
Gross Operating Revenue	\$ <u> </u>	\$ <u> </u>
C. Deductions from Gross Operating Revenue		
1. Contractual Adjustments	\$ <u> </u>	\$ <u> </u>
2. Provision for Charity Care	<u> </u>	<u> </u>
3. Provisions for Bad Debt	<u> </u>	<u> </u>
Total Deductions \$ <u> </u> \$ <u> </u>		
NET OPERATING REVENUE	\$ <u>649,084</u>	\$ <u>649,084</u>
D. Operating Expenses		
1. Salaries and Wages	\$ <u>273,000</u>	\$ <u>273,000</u>
2. Physician's Salaries and Wages	<u> </u>	<u> </u>
3. Supplies	<u>9,000</u>	<u>9,000</u>
4. Taxes	<u>26,000</u>	<u>26,000</u>
5. Depreciation	<u>2,400</u>	<u>2,400</u>
6. Rent	<u> </u>	<u> </u>
7. Interest, other than Capital	<u> </u>	<u> </u>
8. Management Fees:		
a. Fees to Affiliates	<u> </u>	<u> </u>
b. Fees to Non-Affiliates	<u> </u>	<u> </u>
9. Other Expenses (Specify) Professional Fees	<u>129,000</u>	<u>410,400</u>
Total Operating Expenses	\$ <u>439,400</u>	\$ <u>410,400</u>
E. Other Revenue (Expenses) -- Net (Specify)	\$ <u> </u>	\$ <u> </u>
NET OPERATING INCOME (LOSS)	\$ <u>209,684</u>	\$ <u>238,684</u>
F. Capital Expenditures		
1. Retirement of Principal	\$ <u> </u>	\$ <u> </u>
2. Interest	<u> </u>	<u> </u>
Total Capital Expenditures	\$ <u> </u>	\$ <u> </u>
NET OPERATING INCOME (LOSS)		
LESS CAPITAL EXPENDITURES	\$ <u>209,684</u>	\$ <u>238,684</u>

6. A. Please provide the current and proposed charge schedules for the proposal. Discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the proposed project and the impact on existing patient charges.

Response: Hero charges 74.30 an hour for 24/7 skilled nursing services provided to Patient X . The Applicant does not anticipate any change in its charges.

- B. Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

Response: The Applicants charges are at the payment rates set by the EEOICP. The chart below shows the charges and costs of the other home health providers in Anderson County and Morgan County who are also EEOICP providers. Although because of the 24/7 nature of the Applicant's service, the charges of other providers are not comparable The Applicant's charges for skilled nursing care are below the charges of the other home health agency providing the most similar services.

Cost Per Visit	
Agency*	Skilled Nursing Care
1	\$46
2	\$110
3	\$175
4	\$153
5	\$123
6	NA
7	NA
8	\$84
9	\$163
10	\$93
11	\$121
12	NA
Average Charge Per Visit	
Agency*	Skilled Nursing Care
1	NA
2	NA
3	\$160
4	NA
5	NA
6	NA
7	\$1,260
8	NA
9	NA
10	NA

11	NA
12	NA
Average Charge Per Hour	
Agency*	Skilled Nursing Care
1	NA
2	NA
3	\$24
4	NA
5	NA
6	NA
7	\$90
8	NA
9	NA
10	NA
11	NA
12	\$74.30

Source: 2014 Joint Annual Reports, Hero Healthcare, LLC Management and United States Department of Labor, Office of Workers' Compensation Programs

*Key to Agencies:

1. Amedysis Home Health Care (Knox; ID 47202)
2. Blount Memorial Home Services (Blount; ID 05012)
3. Camellia Home Health (Knox; ID 47062)
4. Clinch River Home Health (Anderson; ID 01032)
5. Covenant Homecare & Hospice (Knox; ID 47402)
6. Professional Case Management of Tennessee (Anderson; ID 01042)
7. The Home Option by Harden Health Care (Knox; ID 47372)
8. Sunbelt Homecare (Campbell; ID 07032)
9. Tennova Home Health (Knox; ID 47092)
10. University of Tennessee Medical Center Home Care Services (Knox; ID 47132)
11. Gentiva Health Services (Knox; ID 47042)
12. Hero Proposed Agency**

7. Discuss how projected utilization rates will be sufficient to maintain cost-effectiveness.

Response: Not applicable.

8. Discuss how financial viability will be ensured within two years; and demonstrate the availability of sufficient cash flow until financial viability is achieved.

Response: Hero is and will remain financial viable through the end of Patient X's life.

9. Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid, and medically indigent patients will be served by the project. In addition, report the estimated dollar amount of revenue and percentage of total project revenue anticipated from each of TennCare, Medicare, or other state and federal sources for the proposal's first year of operation.

Response: Hero's services to Patient X are paid by the EEOICP. Hero does not participate in any other state or federal programs

10. Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For new projects, provide financial information for the corporation, partnership, or principal parties involved with the project. Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as Attachment C Economic Feasibility 10.

Response: Please see copies of Hero's Balance Sheet and Income Statement as Attachment C Economic Feasibility 10.

11. Describe all alternatives to this project which were considered and discuss the advantages and disadvantages of each alternative including but not limited to:

- a. A discussion regarding the availability of less costly, more effective, and/or more efficient alternative methods of providing the benefits intended by the proposal. If development of such alternatives is not practicable, the applicant should justify why not; including reasons as to why they were rejected.

Response: There are no less costly or more efficient alternatives to the project. Hero is providing the full range of care 24/7 at total cost below other home health providers in the Service Area and there are no costs associated with the project other than those associated with the filing of this Application. Hero has limited administrative costs and Ms. Young is compensated for her 60 hours a week of services as an owner and is not compensated as an employee of the Applicant.

- b. The applicant should document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements. It should be documented that superior alternatives have been implemented to the maximum extent practicable.

Response: Hero considered the alternative of discontinuing care to Patient X but did not believe it was in the best interest of his physical and mental health. No other alternative was available for the Applicant to continue to provide care to Patient X.

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

1. List all existing health care providers (e.g., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, e.g., transfer agreements, contractual agreements for health services.

Response: Hero is a contracted provider under EEOICP. In addition, Hero contracts with a registered nurse to provide certain of the nursing services. Hero has no other plans to contract with other health care providers.

2. Describe the positive and/or negative effects of the proposal on the health care system. Please be sure to discuss any instances of duplication or competition arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.

Response: Hero's services are limited to a single patient for the duration of his life. They will have no effect on the utilization rates of existing providers in Anderson or Morgan Counties. No services will be provided in Morgan County. According to the 2014 Joint Annual Reports, there are 2614 patients receiving home health services in Anderson County and 490 patients receiving home health services in Morgan County. One patient is less than .04 percent of the patients receiving home health services in Anderson County and the limited services provided by the Applicant will have no effect on the health care system in the service area.

3. Provide the current and/or anticipated staffing pattern for all employees providing patient care for the project. This can be reported using FTEs for these positions. Additionally, please compare the clinical staff salaries in the proposal to prevailing wage patterns in the service area as published by the Tennessee Department of Labor & Workforce Development and/or other documented sources.

Response: The Applicant employees 3 FTE LPNS and 1 PTE. All are paid \$26.00 per hour. Hero contracts with a registered nurse to provide 4 hours of care a month at \$30.00 per hour. According to Tennessee Department of Labor and Workforces 2013 Census of Employment and Wages, the average weekly salary in the health care industry was \$830 a week which in a 40 hour week is 20.75 an hour. Based on a 40 hour week, the Applicants FTE's make \$1040 a week which is 20 % higher than the 2013 average for individuals in the health care industry in Anderson county.

4. Discuss the availability of and accessibility to human resources required by the proposal, including adequate professional staff, as per the Department of Health, the Department of Mental Health and Developmental Disabilities, and/or the Division of Mental Retardation Services licensing requirements.

Response: There is adequate staff for Hero to provide services to a single patient in Anderson County.

5. Verify that the applicant has reviewed and understands all licensing certification as required by the State of Tennessee for medical/clinical staff. These include, without limitation, regulations concerning physician supervision, credentialing, admission privileges, quality assurance policies and programs, utilization review *policies and programs, record keeping, and staff education.*

Response: Hero understands the requirements for licensing. If granted a CON, Hero will maintain all requirements of licensing.

6. Discuss your health care institution's participation in the training of students in the areas of medicine, nursing, social work, etc. (e.g., internships, residencies, etc.).

Response: Not applicable.

7. (a) Please verify, as applicable, that the applicant has reviewed and understands the licensure requirements of the Department of Health, the Department of Mental Health and Developmental Disabilities, the Division of Mental Retardation Services, and/or any applicable Medicare requirements.

Response: Hero understands the licensing requirements of the Department of Health and other requirements which are applicable.

- (b) Provide the name of the entity from which the applicant has received or will receive licensure, certification, and/or accreditation.

Licensure: Hero will be licensed by the State of Tennessee, Department of Health, Board for Licensing Health Care Facilities.

Accreditation: None

- (c) If an existing institution, please describe the current standing with any licensing, certifying, or accrediting agency. Provide a copy of the current license of the facility.
- (d) For existing licensed providers, document that all deficiencies (if any) cited in the last licensure certification and inspection have been addressed through an approved plan of correction. Please include a copy of the most recent licensure/certification inspection with an approved plan of correction.

8. Document and explain any final orders or judgments entered in any state or country by a licensing agency or court against professional licenses held by the applicant or any entities or persons with more than a 5% ownership interest in the applicant. Such information is to be provided for licenses regardless of whether such license is currently held.

Response: Not Applicable

9. Identify and explain any final civil or criminal judgments for fraud or theft against any person or entity with more than a 5% ownership interest in the project

Response: Not Applicable

10. If the proposal is approved, please discuss whether the applicant will provide the Tennessee Health Services and Development Agency and/or the reviewing agency information concerning the number of patients treated, the number and type of

procedures performed, and other data as required.

Response: The Applicant will provide the Tennessee Health Services and Development Agency and/or the reviewing agency with relevant information concerning the number of patients treated and such other data as may be required.

**PROOF OF
PUBLICATION**

Attach the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper as proof of the publication of the letter of intent.

Response: A copy of the publication affidavit is provided on the following page.

To: BONE MCALLESTER NORTON PLLC

(Advertising) NOTIFICATION OF INTENT TO APPLY FOR (Ref No: 499217)

P.O.#: certificate of need

PUBLISHER'S AFFIDAVIT

State of Tennessee }

S.S

County of Knox }

Before me, the undersigned, a Notary Public in and for said county, this day personal Watkins first duly sworn, according to law, says that he/she is a duly authorized repre Knoxville News-Sentinel, a daily newspaper published at Knoxville, in said county at the advertisement of:

(The Above-Referenced)

of which the annexed is a copy, was published in said paper on the following date(s):
04/07/15 Tue

and that the statement of account herewith is correct to the best of his/her knowledge belief.

Louise Watkins

Subscribed and sworn to before me this 7th day of April 20 15

Karan Dixon

Notary Public

My commission expires June 26, 2017 20 17

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that Hero Healthcare LLC ("Applicant") owned and managed by Hero Healthcare LLC with Shariyn Young as sole member and with an ownership type of Limited Liability Company intends to file an application for a Certificate of Need to establish a home health agency in Anderson and Morgan counties but restricted to provide home health care services to a single patient in Anderson County, at a project cost estimated at \$28,000.00. The Applicant's principal office will be located at 231 Walls Hollow Road, Oliver Springs, Morgan County, Tennessee 37840. Therefore, the Applicant is seeking a Certificate of Need for both Anderson and Morgan counties.

At this time, the Applicant holds no existing license but will seek to be licensed as a home health agency by the Board for Licensing Health Care Facilities.

The anticipated date of filing the application is on or before April 10, 2015. The Applicant's contact person for this project is Anne Sumpter Arney, Attorney, who may be reached at Bone McAllester Norton PLLC, 511 Union Street, Suite 1600, Nashville, Tennessee 37219; (615) 238-6300.

Upon written request by interested parties, a local fact-finding public hearing shall be conducted. Written requests should be sent to:

Health Services and Development
Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled. Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.



DEVELOPMENT SCHEDULE

Tennessee Code Annotated § 68-11-1609(c) provides that a Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificates of Need for good cause shown. Subsequent to granting the Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.

1. Please complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.
2. If the response to the preceding question *indicates that the applicant does not anticipate completing the project within the period of validity as defined in the preceding paragraph*, please state below any request for an extended schedule and document the “good cause” for such an extension.

Form HF0004
Revised 02/01/06
Previous Forms are obsolete

PROJECT COMPLETION FORECAST CHART

Enter the Agency projected Initial Decision date, as published in T.C.A. § 68-11-1609(c): July 22, 2015

Assuming the CON approval becomes the final agency action on that date; indicate the number of days from the above agency decision date to each phase of the completion forecast.

<u>Phase</u>	<u>DAYS REQUIRED</u>	<u>Anticipated Date (MONTH/YEAR)</u>
1. <u>Architectural and engineering contract signed</u>	_____	_____
2. <u>Construction documents approved by the Tennessee Department of Health</u>	_____	_____
3. <u>Construction contract signed</u>	_____	_____
4. <u>Building permit secured</u>	_____	_____
5. <u>Site preparation completed</u>	_____	_____
6. <u>Building construction commenced</u>	_____	_____
7. <u>Construction 40% complete</u>	_____	_____
8. <u>Construction 80% complete</u>	_____	_____
9. <u>Construction 100% complete (approved for occupancy)</u>	_____	_____
10. <u>*Issuance of license</u>	_____	<u>July 2015</u>
11. <u>*Initiation of service</u>	_____	<u>July 2015</u>
12. <u>Final Architectural Certification of Payment</u>	_____	_____
13. <u>Final Project Report Form (HF0055)</u>	_____	_____

* For projects that do NOT involve construction or renovation: Please complete items 10 and 11 only.

Note: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.

AFFIDAVIT

STATE OF Tennessee

COUNTY OF Davidson

Anne Supter Army, being first duly sworn, says that he/she is the applicant named in this application or his/her/its lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. § 68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete.

Anne Supter Army
SIGNATURE/TITLE

Sworn to and subscribed before me this 10th day of April, 2015 a Notary
(Month) (Year)

Public in and for the County/State of Davidson County, Tennessee

Kristie Putman
NOTARY PUBLIC

My commission expires May 5, 2016
(Month/Day) (Year)





STATE OF TENNESSEE
Tre Hargett, Secretary of State
Division of Business Services
William R. Snodgrass Tower
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102

BONE MCALLESTER NORTON PLLC
SUITE 1600
511 UNION STREET
NASHVILLE, TN 37219

April 9, 2015

Request Type: Certificate of Existence/Authorization
Request #: 0159026

Issuance Date: 04/09/2015
Copies Requested: 1

Document Receipt

Receipt #: 001997450

Filing Fee: \$22.25

Payment-Credit Card - State Payment Center - CC #: 161793903

\$22.25

Regarding: Hero Healthcare LLC

Filing Type: Limited Liability Company - Domestic

Control #: 763234

Formation/Qualification Date: 07/02/2014

Date Formed: 07/02/2014

Status: Active

Formation Locale: TENNESSEE

Duration Term: Perpetual

Inactive Date:

Business County: MORGAN COUNTY

CERTIFICATE OF EXISTENCE

I, Tre Hargett, Secretary of State of the State of Tennessee, do hereby certify that effective as of the issuance date noted above

Hero Healthcare LLC

- * is a Limited Liability Company duly formed under the law of this State with a date of incorporation and duration as given above;
- * has paid all fees, taxes and penalties owed to this State (as reflected in the records of the Secretary of State and the Department of Revenue) which affect the existence/authorization of the business;
- * has appointed a registered agent and registered office in this State;
- * has not filed Articles of Dissolution or Articles of Termination. A decree of judicial dissolution has not been filed.

Tre Hargett
Secretary of State

Verification #: 011443526

Processed By: Cert Web User



STATE OF TENNESSEE
Tre Hargett, Secretary of State
Division of Business Services
William R. Snodgrass Tower
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102

BONE MCALLESTER NORTON PLLC
STE 1600
511 UNION ST
NASHVILLE, TN 37219-1780

Request Type: Certified Copies
Request #: 141122

Issuance Date: 10/03/2014
Copies Requested: 1

Document Receipt

Receipt #: 1660872 Filing Fee: \$20.00
Payment-Check/MO - BONE MCALLESTER NORTON PLLC, NASHVILLE, TN \$20.00

I, Tre Hargett, Secretary of State of the State of Tennessee, do hereby certify that **Hero Healthcare LLC**, Control # 763234 was formed or qualified to do business in the State of Tennessee on 07/02/2014. Hero Healthcare LLC has a home jurisdiction of TENNESSEE and is currently in an Active status. The attached documents are true and correct copies and were filed in this office on the date(s) indicated below.


Tre Hargett
Secretary of State


Processed By: Nichole Hambrick


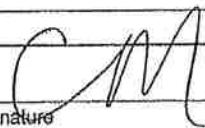
The attached document(s) was/were filed in this office on the date(s) indicated below:

<u>Reference #</u>	<u>Date Filed</u>	<u>Filing Description</u>
7356-2932	07/02/2014	Initial Filing

4

7356.2932, 07/02/2014, 11:11:56, Received by Tennessee Secretary of State Tre Hargett

ARTICLES OF ORGANIZATION LIMITED LIABILITY COMPANY	
 <p>Business Services Division Tre Hargett, Secretary of State State of Tennessee 312 Rosa L. Parks AVE, 6th FL Nashville, TN 37243-1102 (615) 741-2286</p> <p>Filing Fee: \$50.00 per member (minimum fee = \$300, maximum fee = \$3,000)</p>	<i>For Office Use Only</i>
The Articles of Organization presented herein are adopted in accordance with the provisions of the Tennessee Revised Limited Liability Company Act.	
1. The name of the Limited Liability Company is: <u>Hero Healthcare LLC</u> (NOTE: Pursuant to the provisions of T.C.A. §48-249-106, each Limited Liability Company name must contain the words "Limited Liability Company" or the abbreviation "LLC" or "L.L.C.")	
2. Name Consent: (Written Consent for Use of Indistinguishable Name) <input type="checkbox"/> This entity name already exists in Tennessee and has received name consent from the existing entity.	
3. This company has the additional designation of: _____	
4. The name and complete address of the Limited Liability Company's initial registered agent and office located in the state of Tennessee is: Name: <u>United States Corporation Agents, Inc.</u> Address: <u>3903 Volunteer Drive, Suite 200</u> City: <u>Chattanooga</u> State: <u>Tennessee</u> Zip Code: <u>37416</u> County: <u>Hamilton County</u>	
5. Fiscal Year Close Month: <u>July 31</u>	
6. If the document is not to be effective upon filing by the Secretary of State, the delayed effective date and time is: (Not to exceed 90 days) Effective Date: ____/____/____ Time: ____ <div style="text-align: center; font-size: small;"> Month Day Year </div>	
7. The Limited Liability Company will be: <input checked="" type="checkbox"/> Member Managed <input type="checkbox"/> Manager Managed <input type="checkbox"/> Director Managed	
8. Number of Members at the date of filing: <u>1</u>	
9. Period of Duration: <input checked="" type="checkbox"/> Perpetual <input type="checkbox"/> Other ____/____/____ <div style="text-align: center; font-size: small;"> Month Day Year </div>	
10. The complete address of the Limited Liability Company's principal executive office is: Address: <u>231 Walls Hollow Road</u> City: <u>Oliver Springs</u> State: <u>Tennessee</u> Zip Code: <u>37840</u> County: <u>Morgan</u>	

ARTICLES OF ORGANIZATION LIMITED LIABILITY COMPANY	
<div style="display: flex; justify-content: space-between; align-items: center;"> <div style="text-align: center;">  </div> <div> <p>Business Services Division Tre Hargett, Secretary of State State of Tennessee 312 Rosa L. Parks AVE, 6th Fl. Nashville, TN 37243-1102 (615) 741-2286</p> <p>Filing Fee: \$50.00 per member (minimum fee = \$300, maximum fee = \$3,000)</p> </div> </div>	<i>For Office Use Only</i>
The name of the Limited Liability Company is: <u>Hero Healthcare LLC</u>	
11. The complete mailing address of the entity (if different from the principal office) is: Address: _____ City: _____ State: _____ Zip Code: _____	
12. Non-Profit LLC (required only if the Additional Designation of "Non-Profit LLC" is entered in section 3.) <input type="checkbox"/> I certify that this entity is a Non-Profit LLC whose sole member is a nonprofit corporation, foreign or domestic, incorporated under or subject to the provisions of the Tennessee Nonprofit Corporation Act and who is exempt from franchise and excise tax as not-for-profit as defined in T.C.A. §67-4-2004. The business is disregarded as an entity for federal income tax purposes.	
13. Professional LLC (required only if the Additional Designation of "Professional LLC" is entered in section 3.) <input type="checkbox"/> I certify that this PLLC has one or more qualified persons as members and no disqualified persons as members or holders. Licensed Profession: _____	
14. Series LLC (required only if the Additional Designation of "Series LLC" is entered in section 3.) <input type="checkbox"/> I certify that this entity meets the requirements of T.C.A. §48-249-309(a) & (b)	
15. Obligated Member Entity (list of obligated members and signatures must be attached) <input type="checkbox"/> This entity will be registered as an Obligated Member Entity (OME) Effective Date: _____ <div style="text-align: center; font-size: small;"> _____ Month Day Year </div> <input type="checkbox"/> I understand that by statute: THE EXECUTION AND FILING OF THIS DOCUMENT WILL CAUSE THE MEMBER(S) TO BE PERSONALLY LIABLE FOR THE DEBTS, OBLIGATIONS AND LIABILITIES OF THE LIMITED LIABILITY COMPANY TO THE SAME EXTENT AS A GENERAL PARTNER OF A GENERAL PARTNERSHIP. CONSULT AN ATTORNEY.	
16. This entity is prohibited from doing business in Tennessee: <input type="checkbox"/> This entity, while being formed under Tennessee law, is prohibited from engaging in business in Tennessee.	
17. Other Provisions: _____ _____ _____	
<u>7/01/2014</u> Signature Date	 Signature
Organizer, Assistant Secretary, LegalZoom.com, Inc. Signer's Capacity (if other than individual capacity)	<u>Cheyenne Moseley</u> Name (printed or typed)

LEASE AGREEMENT

THIS LEASE AGREEMENT (the "Lease"), dated as of August 2, 201⁵⁴~~4~~ is by and between Joel G. Scarbrough, a resident of Morgan County, Tennessee ("Lessor"), and Hero Healthcare LLC, a Tennessee limited liability company ("Lessee").

NOW THEREFORE, in consideration of the mutual covenants contained herein, the parties agree as follows:

1. Space, Term. The Lessor agrees to allow the Lessee to use such space as Lessee may reasonably require as a home office for the business operations of Lessee at 321 Wallis Hollow road, Oliver Springs, Tennessee (the " "), for the term of five (5) years from the 1st day of September, 2014 to the 1st day of September, 2019 ("Term"). Lessee may terminate this Lease without penalty upon thirty (30) days written notice to Lessor

2. Rent. During the Term of this Lease, Lessee shall pay to Lessor at the address specified below without notice or demand, the rent for the Space (the "Rent"), which shall be payable in arrears annually on the anniversary day of the Term without deduction or offset of any sort. Rent shall be one hundred dollars (\$100) per year. Lessor shall be responsible for all utilities, taxes, maintenance of the Space other than any cost that results in Lessee's breach of this Lease.

3. Default. The happening of any one or more of the following listed events ("Event of Default") shall constitute a breach of this Lease on the part of Lessee:

(a) the failure of Lessee to make the payments of Rent as required herein;

(b) the failure of Lessee materially to comply with any terms or provisions hereof (other than the payment of Rent) after thirty (30) days prior written notice of such default; or

(c) The commencement of any proceeding against Lessee under any bankruptcy or insolvency law, or the appointment of a receiver, levy of execution, attachment, or other taking of any part of the property of Lessee, or any assignment for the benefit of creditors by Lessee.

4. Remedies. Notwithstanding any other provision of this Lease, upon the happening of any Event of Default, and the expiration of any applicable cure period, Lessor may terminate Lessee's right to possession but not terminate the Agreement and/or proceed, by summary proceeding or otherwise and without further notice, reenter the Space either by force or otherwise and dispossess Lessee or any other occupant of the Space, remove their effects, and hold the Space as if this Agreement had not been made, and Lessee hereby waives the service of notice of intention to reenter or to institute legal proceedings to that end. In addition, Lessor may require Lessee or its legal representative(s) to also pay to Lessor any deficiency between the rent and all additional rent hereby reserved and/or agreed to be paid and the net amount, if any, of the rents collected on account of the lease or leases of the Space for each month of the period which would otherwise have constituted the balance of the lease Term.

4. Assignment and Subletting. This Lease may not be assigned or sublet by Lessee in any manner whatever.

5. Termination of Lease or Suspension of Rent in Case of Fire. In case the Space or any part thereof shall at any time during the Term be destroyed or damaged by fire or other unavoidable casualty so as to be unfit for occupancy and use, and so that the Space cannot be rebuilt or restored by the Lessor within one hundred eighty (180) days thereafter, then this Lease shall terminate; but if the Space can be rebuilt or restored within one hundred eighty (180) days the Lessor will at Lessor's own expense and with due diligence so rebuild or restore the Space, and a just and proportionate part of the rents hereby reserved shall be paid by the Lessee until the Space shall have been so rebuilt or restored.

6. Termination of Lease or Suspension of Rent in Case of Taking by Eminent Domain. If the whole or a substantial part of the Space is taken by the city or state or other public authority for any public use, then this Lease shall terminate from the time when possession of the whole or of the part so taken shall be required for such public use, and the rents, properly apportioned, shall be paid up to that time; and the Lessee shall not claim or be entitled to any part of the award to be made for damages for such taking for public use; and such taking shall not be deemed a breach of the Lessor's covenant for quiet enjoyment hereinbefore contained.

7. Entire Agreement. This Lease contains the entire agreement between the parties and cannot be amended unless the amendment is in writing and executed by both parties.

8. Notices. All notices, offers, requests, demands, and other communications pursuant to this Lease shall be given in writing by personal delivery, by prepaid first class registered or certified mail properly addressed with appropriate postage paid thereon, or by telecopier, or facsimile transmission, and shall be deemed to be duly given and received on the date of delivery if delivered personally, on the second day after the deposit in the United States Mail if mailed, or upon acknowledgment of receipt of electronic transmission if sent by telecopier or facsimile transmission. Notices shall be sent to the parties at the following addresses:

If to Lessor:

If to Lessee:

Or to such other address as any party may have furnished to the other in writing in accordance herewith, except that notices of change of address shall only be effective upon receipt.

9. Severability. In the event that any provision of this Lease, or the application thereof to any person or circumstance, is held by a court of competent jurisdiction to be invalid, illegal or unenforceable in any respect in any jurisdiction, such invalidity, illegality or unenforceability shall not affect any other provision of this Lease in that jurisdiction or the application of that provision to any other person or circumstance or in any other jurisdiction, and this Lease shall then be construed in that jurisdiction as if such invalid, illegal or unenforceable provision had not

been contained in this Lease, but only to the extent of such invalidity, illegality or unenforceability. In the further event of such determination, the parties shall promptly execute and deliver such amendatory provisions to this Lease as are necessary to accomplish lawfully, and as nearly as possible, the goals and purposes of the provision(s) held to be invalid, illegal or unenforceable.

10. Captions and Headings. The section and paragraph captions and headings contained in this Lease are included for reference purposes only and shall not affect in any way the meaning or interpretation of this Lease.

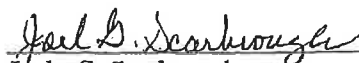
11. Rights Cumulative; No Waiver. No right or remedy herein conferred upon or reserved to either of the parties hereto is intended to be exclusive of any other right or remedy, and each and every right and remedy shall be cumulative and in addition to any other right or remedy given hereunder, or now or hereafter legally existing upon the occurrence of an Event of Default hereunder. The failure of either party to insist at any time upon the strict observance or performance of any of the provisions of this Lease or to exercise any right or remedy as provided in this Lease, shall not impair any such right or remedy or be construed as a waiver or relinquishment thereof with respect to subsequent defaults. Every right and remedy given by this Lease to the parties hereto may be exercised from time to time and as often as may be deemed expedient by the parties, as the case may be.

12. Governing Law; Forum; Service of Process; Venue. This Lease shall be governed by and construed in accordance with the laws of the State of Tennessee. This Lease and its subject matter have substantial contacts with Tennessee, and all actions, suits, or other proceedings with respect to this Lease shall be brought only in a court of competent jurisdiction sitting in Rutherford County, Tennessee, or in the United States District Court having jurisdiction over that County. In any such action, suit, or proceeding, such court shall have personal jurisdiction of all of the parties hereto, and service of process upon them under any applicable statutes, laws, and rules shall be deemed valid and good.

13. Attorney Fees. In the event either party hereto fails to perform any of its obligations under this Lease or in the event a dispute arises concerning the meaning or interpretation of any provision of this Lease, the defaulting party or the party not prevailing in such dispute, as the case may be, shall pay any and all costs and expenses incurred by the other party in enforcing or establishing its rights hereunder, including, without limitation, court costs and reasonable attorney fees.

IN WITNESS WHEREOF, the parties thereto have executed this Agreement as of the date, month and year first above written.

LESSOR:


Joel G. Scarbrough

Attachment A - 6

LESSEE:

Hero Healthcare, LLC

By: Sharlyn Young, president
Sharlyn Young, president

Attachment C Need -1(1)

February 25, 2015

[REDACTED]
[REDACTED]
[REDACTED]

To whom it may concern:

This letter is written on behalf of my father, and this family. My father's care is provided by the Department of Labor, Energy Compensation, due to his employment with the Department of Energy at the K-25 plant in Oak Ridge, TN. He suffers from multiple diagnosis related to chemical exposure.

After multiple times of having no staff with him, and calling Ms. Young to come in and care for him, my father decided to ask MS Young to oversee his care through the Department of Labor, after several months passed and the problems continued, she agreed.

My father has been provided constant care under her supervision, never a shift missed. He is very happy with the care he is receiving, as is his family. My father has three sons one is a over the road truck driver, one lives in California, and I work construction, with very odd hours, he is unable to care for himself and needs assist, as you can see we cannot provide his care, and we must be dependent on his caregiver and with MS Young we are able to do that.

While my father has sound mind, he is forgetful, does not hear well, blind in the left eye and little vision in his right eye, he is well-adjusted to his care giving staff. I feel that any change in his routine would be very devastating to him.

My father believes he has paid for his care with his health and should choose who takes care of him, in his last days.

Thank You, [REDACTED]

[REDACTED]

and family

[REDACTED]

Feb. 25, 15

Attachment C Need 1 (1)

March 11, 2015

To whom it may concern:

I write this letter in support of my father, and his home health care supplied by Hero Healthcare LLC, Ms. Sharlyn Young, it was my father's decision, with the support of his family to seek other health care for him, when [REDACTED] failed to provide him with proper care. I feel my father is very happy with his care, I do not believe he could be better served, and it would be detrimental to his health to change his service, I believe it has the right, to be happy and feel secure in his home, and I strongly believe he has paid for his service, with the loss his health, and should have the right to determine who cares for him.

Sincerely, [REDACTED]

Attachment C Need -1(3)

Morgan County Government

Don Edwards, Executive
415 N. Kingston St.
PO Box 387
Wartburg, TN 37887



Don Edwards, Chairman
(423) 346-6288
Fax: (423) 346-9707
edwardsd@mcsed.net

Morgan County is a community where God is honored, where our children are safe and well educated, and where hard working, industrious citizens have ample opportunity for good jobs.

March 2, 2015

Tennessee Dept. Of Health
Health Services Development Agency

Sirs and Madams,

Mrs. Sharlyn Young is making an application for a "**Certificate of Need**" license with the State of Tennessee in order to serve the citizens of Morgan County. At present, Mrs. Young has only one client for whom she is providing care. That care is 24/7.

As you know, Morgan County is an economically disadvantaged county with historically higher than the state average unemployment, high poverty rates, and low levels of family income. The type of service that Mrs. Young is providing is very much needed in our county due to the high numbers of elderly and disabled citizens among us. The service that Mrs. Young will be providing can be a good source of income for some of our citizens who desperately need decent paying jobs.

It is my understanding that Mrs. Young will be the only "**Certificate of Need**" license holder in Morgan County though we have outside companies operating within the borders of our county. Mrs. Young has been a healthcare professional for many years and it will be in the best interest of Morgan County for her application to be approved.

If you need further information or comment from Morgan County, please don't hesitate to contact me. I am

Sincerely Yours,

Don Edwards
Morgan County Executive
Commission Chairman

HERO HEALTHCARE'S
PROPOSED SERVICE AREA

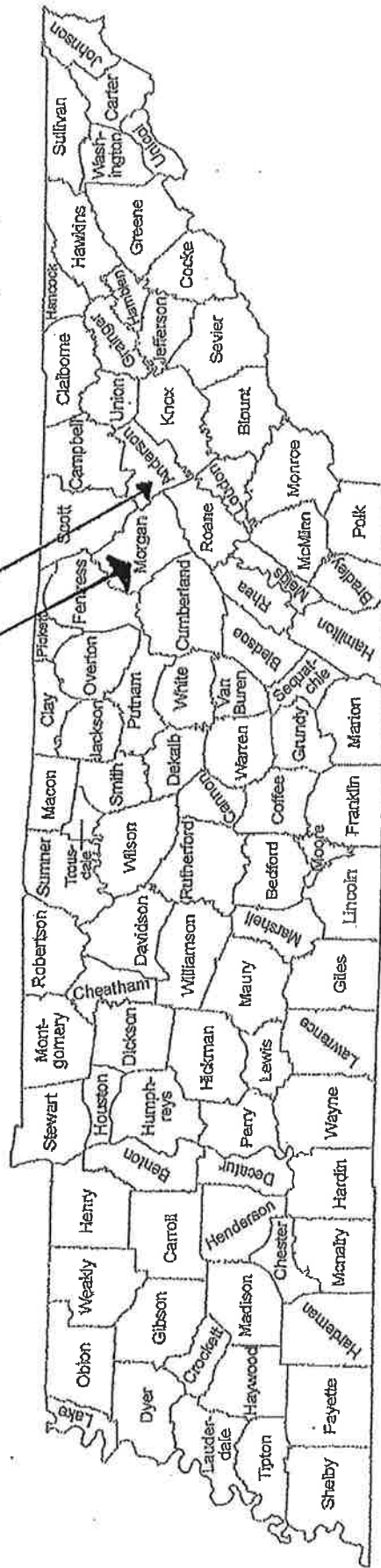


Chart 1

Attachment: C Need 4 A

Demographic Characteristics of Project Service Area

Hero Healthcare LLC

2014 - 2018

Demographic	Anderson County	Morgan County	State of Tennessee
Median Age - 2010 US Census	42.6	39.8	38
Total Population - 2014	76,579	21,848	6,588,698
Total Population - 2018	77,851	22,004	6,833,509
Total Population - % Change 2014 to 2018	1.7%	0.7%	1.7%
Age 65+ Population - 2014	14,531	3,436	981,984
% of Total Population	18.98%	15.73%	14.90%
Age 65+ Population - 2018	16,277	3,796	1,102,413
% of Total Population	20.9%	17.3%	16.1%
Age 65 + Population - % Change 2014 - 2018	12.0%	10.5%	12.3%
Age 15-64 Population - 2014	49,453	14,949	4,359,085
% of Total Population	64.6%	68.4%	66.2%
Age 15-64 Population - 2018	47,938	14,881	4,467,503
% of Total Population	61.6%	67.6%	65.4%
Age 0-14 Population - 2014	12,595	3,463	1,247,629
% of Total Population	16.4%	15.9%	18.9%
Age 0-14 Population - 2018	12,957	3,327	1,263,593
% of Total Population	16.6%	15.1%	18.5%
Age 0-14 Population - % Change 2014 -2018	2.9%	-3.9%	1.3%
Median Household Income - 2013	\$40,689.00	\$37,631.00	\$44,298.00
TennCare Enrollees (11/14)	15,255	4,531	1,324,208
Percent of 2014 Population Enrolled in TennCare	19.9%	20.7%	20.1%
Persons Below Poverty Level	13,478	3,936	1,159,611
Persons Below Poverty Level as % of Population (US Census)	17.6%	18.0%	17.6%

Sources: TDH Population Projections, June 2013; U.S. Census QuickFacts;TennCare Bureau.

Chart 2
Attachment: C Need 5

Home Health Agencies Licensed to Serve Within the Project Service Area (Anderson County)			
Alphabetical, By Agency Name			
Health Statistics ID	Agency County	Agency	Type
47202	Knox	Amedisys Home Health Care*	Home
13022	Claiborne	Amedisys Home Health of Tennessee	Home
05012	Blount	Blount Memorial Hospital Home Health Services*	Home
47062	Knox	Camellia Home Health of East Tennessee*	Home
01032	Anderson	Clinch River Home Health*	Home
47402	Knox	Covenant Homecare*	Home
47222	Knox	East Tennessee Children's Hospital Home Health Care	Home
19494	Davidson	Elk Valley Health Services LLC	Home
47042	Knox	Gentiva Health Services*	Home
47182	Knox	Girling Health Care, Inc. dba Gentiva Health Services 2	Home
19544	Davidson	LHC HomeCare of Tennessee, LLC dba Home Care Solutions	Home
47372	Knox	Home Option by Harden Health Care*	Home
62052	Monroe	Intrepid USA Healthcare Services	Home
47432	Knox	Maxim Healthcare Services, Inc.	Home
47012	Knox	NHC Homecare	Home
32132	Hamblen	Premier Support Services, Inc.	Home
01042	Anderson	Professional Case Management of Tennessee*	Home
25044	Fentress	Quality Home Health	Home
07032	Campbell	Sunbelt Homecare*	Home
47092	Knox	Tennova Home Health*	Home
47132	Knox	University of TN Medical Center Home Care Services – Home Health*	Home
		Number of Unduplicated Home Health Agencies	21

*Agencies enrolled as providers under the Energy Employees Occupational Illness Compensation Program with the Department of Labor

Chart 2
Attachment: C Need 5

Home Health Agencies Licensed to Serve Within the Project Service Area (Morgan County)			
Alphabetical, By Agency Name			
Health Statistics ID	Agency County	Agency	Type
47202	Knox	Amedisys Home Health Care*	Home
67024	Overton	Amedisys Tennessee, L.L.C.	Home
47062	Knox	Camellia Home Health of East Tennessee*	Home
47232	Knox	CareAll Home Care Services	Home
01032	Anderson	Clinch River Home Health*	Home
47402	Knox	Covenant Homecare*	Home
47222	Knox	East Tennessee Children's Hospital Home Health Care	Home
19494	Davidson	Elk Valley Health Services, LLC	Home
76032	Scott	Elk Valley Home Health Care Agency, LLC	Home
47182	Knox	Girling Health Care, Inc. dba Gentiva Health Services 2	Home
06063	Bradley	Home Health Care of East Tennessee, Inc.	Home
19544	Davidson	LHC HomeCare of Tennessee, LLC dba Home Care Solutions	Home
47432	Knox	Maxim Healthcare Services, Inc.	Home
75024	Rutherford	NHC Homecare	Home
32132	Hamblen	Premier Support Services, Inc.	Home
01042	Anderson	Professional Case Management of Tennessee*	Home
25044	Fentress	Quality Home Health	Home
25034	Fentress	Quality Private Duty Care	Home
07032	Campbell	Sunbelt Homecare*	Home
47092	Knox	Tennova Home Health*	Home
47132	Knox	University of TN Medical Center Home Care Services – Home Health*	Home
		Number of Unduplicated Home Health Agencies	21

*Agencies enrolled as providers under the Energy Employees Occupational Illness Compensation Program with the Department of Labor

Chart 3
Attachment - C Need 5
Existing Agency Patients by Service Area Counties (Anderson County) and Agency Dependence on Service Areas- Alphabetical by Agency Name

Health Statistics ID	Agency County	Agency Name	Number of Counties Agency is Licensed to Serve	No. of Agency's Counties in Project Service Area	Percent of Agency's Counties in Project Service Area	Home Health Patients Served by Agency in Service Area	Total Agency Patients in TN	% of Agency's Total Patients from Service Area
47202	Knox	Amedisys Home Health Care	28	1	3.57%	729	4,391	16.60%
05012	Blount	Blount Memorial Hospital Home Health Services	19	1	5.26%	0	1,281	0%
47062	Knox	Camellia Home Health of East Tennessee	26	1	3.85%	76	1,732	4.39%
01032	Anderson	Clinch River Home Health	7	1	14.29%	241	481	50.10%
47402	Knox	Covenant Homecare	16	1	6.25%	752	4,792	15.69%
47222	Knox	East Tennessee Children's Hospital Home Health Care	16	1	6.25%	43	600	7.17%
19494	Davidson	Elk Valley Health Services LLC	95	1	1.05%	1	293	0.34%
47042	Knox	Gentiva Health Services	16	1	6.25%	22	413	5.33%
47182	Knox	Gifting Health Care, Inc. dba Gentiva Health Services 2	23	1	4.35%	109	1,815	6.01%
19544	Davidson	LHC HomeCare of Tennessee, LLC dba Home Care Solutions	43	1	2.33%	30	1,689	1.78%
47372	Knox	Home Option by Harden Health Care	8	1	12.50%	31	72	43.06%
62052	Monroe	Innrepid USA Healthcare Services	15	1	6.67%	9	355	2.54%
47432	Knox	Maxim Healthcare Services, Inc.	18	1	5.56%	15	154	9.74%
47012	Knox	NHC Homecare	15	1	6.67%	175	883	19.82%
32132	Hamblen	Premier Support Services, Inc.	16	1	6.25%	1	1,372	0.07%
01042	Anderson	Professional Case Management of Tennessee	11	1	9.09%	55	173	31.79%
25044	Fentress	Quality Home Health	13	1	7.69%	139	3,591	3.87%
07032	Campbell	Sundelt Homecare	7	1	14.29%	10	243	4.12%
47092	Knox	Tennova Home Health	15	1	6.67%	149	3,240	4.60%
32122	Hamblen	MorrisTown-Hamblen HomeCare and Hospice, LLC dba University of TN Medical Center Home Health Services	10	1	10.00%	0	751	0.00%
47132	Knox	University of TN Medical Center Home Care Services - Home Health	15	1	6.67%	27	771	3.50%
TOTALS								

Source: Tennessee Department of Health, Health Care Facilities, TSHDA Joint Annual Reports for 2014

Chart 3
Attachment - C Need 5
Existing Agency Patients by Service Area Counties (Morgan County) and Agency Dependence on Service Areas—Alphabetical by Agency Name

Health Statistics ID	Agency County	Agency Name	Number of Counties Agency is Licensed to Serve	No. of Agency's Counties in Project Service Area	Percent of Agency's Counties in Project Service Area	Home Health Patients Served by Agency in Service Area	Total Agency Patients in TN	% of Agency's Total Patients from Service Area
47202	Knox	Amadeus Home Health Care	28	1	3.57%	35	4,391	0.80%
47062	Knox	Camella Home Health of East Tennessee	26	1	3.85%	4	1,732	0.23%
01032	Anderson	Clinch River Home Health	7	1	14.29%	19	481	3.95%
47402	Knox	Covenant Homecare	16	1	6.25%	118	4,792	2.46%
76032	Scott	Elk Valley Home Health Agency, LLC	5	1	20.00%	33	394	8.38%
47222	Knox	East Tennessee Children's Hospital Home Health Care	16	1	6.25%	5	586	0.85%
19494	Davidson	Elk Valley Health Services LLC	95	1	1.05%	3	293	1.02%
47042	Knox	Geniva Health Services	16	1	6.25%	0	413	0.00%
47182	Knox	Girling Health Care, Inc. dba Geniva Health Services 2	18	1	5.56%	17	1,815	0.94%
19544	Davidson	LHC HomeCare of Tennessee, LLC dba Home Care Solutions	46	1	2.17%	4	1,689	0.24%
47432	Knox	Maxim Healthcare Services, Inc.	18	1	5.56%	5	154	3.25%
75024	Rutherford	NHC Homecare	24	1	4.17%	2	3,776	0.05%
32132	Hamblen	Premier Support Services, Inc.	16	1	6.25%	0	1,372	0.00%
01042	Anderson	Professional Case Management of Tennessee	11	1	9.09%	2	173	1.15%
25044	Fentress	Quality Home Health	13	1	7.69%	191	3,591	5.32%
25094	Fentress	Quality Private Duty Care	9	1	11.11%	53	894	5.93%
07032	Campbell	Sunbelt Homecare	7	1	14.29%	1	243	0.41%
47092	Knox	Tennova Home Health	15	1	6.67%	0	3,240	0.00%
32122	Hamblen	Morristown-Hamblen HomeCare and Hospice, LLC dba University of TN Medical Center Home Health Services	10	1	10.00%	0	751	0.00%
47132	Knox	University of TN Medical Center Home Care Services - Home Health	15	1	6.67%	0	771	0.00%
TOTALS								

Sources: Tennessee Department of Health, Health Care Facilities, TSHDA Joint Annual Reports for 2014

Chart 4
Attachment - C, Need 5
2014 Hours & Visits by Discipline for 21 Major Agencies in Service Area --Alphabetical by Agency Name (Anderson County)

			HOURS BY DISCIPLINE				VISITS BY DISCIPLINE									
Health Statistics ID	Agency/County	Agency Name	Home Health Aide	Skilled Nursing	Other	Total Hours, All Disciplines	Home Health Aide	Skilled Nursing2	Occup1 Therapy	Physical Therapy	Speech Therapy	Total, All Therapies	Home maker Services	Medical Social Services	Other2	Total Visits, All Disciplines
47202	Knox	Amedisys Home Health Care*	0	0	0	0	10,603	55,812	11,543	37,504	6,198	121,660	0	2,012	0	123,672
13022	Clatsop	Amedisys Home Health of Tennessee	0	0	0	0	7,791	26,518	6,584	14,548	1,710	57,151	0	454	0	57,605
05012	Blount	Blount Memorial Hospital Home Health Services*	0	0	0	0	3,655	13,328	2,948	9,751	804	30,486	0	469	0	30,955
47062	Knox	Camellia Home Health of East Tennessee*	90,199	220,254	0	310,453	6,044	25,248	7,577	26,308	2,068	67,245	0	440	0	67,685
01032	Anderson	Clinch River Home Health*	0	0	0	0	9,121	5,275	96	4,248	0	18,740	0	109	0	18,849
47402	Knox	Covenant Homecare*	0	0	0	0	7,490	37,621	4,964	29,327	1,645	81,047	0	961	13	82,021
47222	Knox	East Tennessee Children's Hospital Home Health Care	0	0	0	0	0	1,969	1,533	1,627	1,076	6,205	0	407	0	6,612
19494	Davidson	Elk Valley Health Services LLC	0	0	0	0	10,697	24,958	0	0	0	35,655	0	0	0	35,655
47042	Knox	Gentiva Health Services*	0	0	0	0	0	5,132	1,649	2,872	519	10,172	0	221	0	10,393
47182	Knox	Girling Health Care, Inc. dba Gentiva Health Services 2	0	0	0	0	5,833	24,873	9,988	20,833	3,445	64,972	0	874	0	65,846
19544	Davidson	LHC HomeCare of Tennessee, LLC dba Home Care Solutions	0	0	0	0	5,087	36,585	6,526	23,957	2,208	74,363	0	1,099	0	75,462
47372	Knox	Home Option by Harden Health Care*	0	0	0	0	1,326	2,602	0	0	0	3,928	2,195	0	0	6,123
62052	Monroe	Interpud USA Healthcare Services	0	0	0	0	351	3,369	667	4,623	76	9,086	0	71	0	9,157
47432	Knox	Maxim Healthcare Services, Inc.	71,171	417,959	0	489,130	1	901	0	0	0	902	0	0	0	902
47012	Knox	NHC Homecare	0	0	0	0	483	7,038	579	7,838	246	16,184	0	51	0	16,235
32132	Hamblen	Premier Support Services, Inc.	30,607	142,080	24,548	197,235	2,477	10,950	605	11,698	1,017	26,747	0	330	0	27,077
01042	Anderson	Professional Case Management of Tennessee*	54,080	0	247,520	301,600	0	0	0	0	0	0	0	0	0	0
25044	Fentress	Quality Home Health	148,424	130,499	1,894	280,817	17,259	77,827	1,654	25,518	916	123,174	0	1,470	0	124,644
07032	Campbell	Sunbelt Homecare	0	0	0	0	1,795	8,457	0	1,678	0	11,930	0	0	0	11,930
47092	Knox	Tennova Home Health*	0	0	0	0	7,647	33,448	3,411	22,071	1,239	67,816	0	644	0	68,460
47132	Knox	University of TN Medical Center Home Care Services -- Home Health*	0	0	0	0	427	5,228	951	4,479	311	0	0	64	0	11,460
AUTHORIZED AGENCIES TOTAL			394,481	910,792	273,962	1,579,235	98,087	407,139	61,275	248,880	23,478	827,463	2,195	9,676	13	830,743

Source: TDH HHA Joint Ann. Reports, 2014, pp 6-8

*Agencies enrolled as providers with the Department of Labor

Chart 4
Attachment - C, Need 5
2014 Hours & Visits By Discipline for 21 Major Agencies in Service Area --Alphabetical by Agency Name (Morgan County)

			HOURS By Discipline					VISITS By Discipline								
Health Statistics ID	Agency County	Agency Name	Home Health Aide	Skilled Nursing	Other	Total Hours, All Disciplines	Home Health Aide	Skilled Nursing#2	Occup#1 Therapy	Physical Therapy	Speech Therapy	Total, All Therapies	Home maker Services	Medical Social Services	Other#2	Total Visits, All AP
47202	Knox	Amedisys Home Health Care*	0	0	0	0	10,603	55,812	11,543	37,504	6,198	121,660	0	2,012	0	123,672
67074	Overton	Amedisys Tennessee, L.L.C.	0	0	0	0	2,567	13,174	899	8,318	680	26,138	0	498	0	26,636
47062	Knox	Camellia Home Health of East Tennessee*	90,499	220,254	0	310,453	6,044	25,248	7,577	26,308	2,068	67,245	0	440	0	67,685
47232	Knox	CareAll Home Care Services	9,493	21,878	1,382	32,753	1,069	3,928	0	4,975	0	9,972	0	20	0	9,992
01032	Anderson	Cinch River Home Health*	0	0	0	0	9,121	5,275	96	4,248	0	18,740	0	109	0	18,849
47402	Knox	Covenant Homecare*	0	0	0	0	7,490	37,621	4,964	29,327	1,645	81,047	0	961	13	82,021
76032	Scott	Eik Valley Home Health Care Agency, LLC	0	0	0	0	2,281	9,574	2,079	2,777	257	16,968	0	0	0	16,968
47222	Knox	East Tennessee Children's Hospital Home Health Care	0	0	0	0	0	1,969	1,533	1,627	1,076	6,205	0	407	0	6,612
19494	Davidson	Eik Valley Health Services, LLC	0	0	0	0	10,697	24,958	0	0	0	35,655	0	0	0	35,655
47182	Knox	Gifting Health Care, Inc. dba Gentiva Health Services 2	0	0	0	0	5,833	24,873	9,988	20,833	3,445	64,972	0	874	0	65,846
06063	Bradley	Home Health Care of East Tennessee, Inc.	104,043	131,511	0	235,554	17,799	27,023	1,922	23,380	857	70,981	0	575	0	71,556
19544	Davidson	LHC HomeCare of Tennessee, LLC dba Home Care Solutions	0	0	0	0	5,087	36,585	6,526	23,957	2,208	74,363	0	1,099	0	75,462
47432	Knox	Maxim Healthcare Services, Inc.	71,171	417,959	0	489,130	1	901	0	0	0	902	0	0	0	902
75024	Rutherford	NHC Homecare	0	0	0	0	9,771	47,108	5,401	35,845	1,134	99,259	0	471	0	99,730
32132	Hamblen	Premier Support Services, Inc.	30,607	142,080	24,548	197,235	2,477	10,950	605	11,698	1,017	26,747	0	330	0	27,077
01042	Anderson	Professional Case Management of Tennessee*	54,080	0	247,520	301,600	0	0	0	0	0	0	0	0	0	0
25044	Fentress	Quality Home Health	148,424	130,499	1,894	280,817	17,259	77,827	1,654	25,518	916	123,174	0	1,470	0	124,644
25034	Fentress	Quality Private Duty Care	546,085	81,938	22,441	650,464	0	0	0	0	0	0	0	0	0	0
07032	Campbell	Sunbelt Homecare*	0	0	0	0	1,795	8,457	0	1,678	0	11,930	0	0	0	11,930
47092	Knox	Tennova Home Health*	0	0	0	0	7,647	33,448	3,411	22,071	1,239	67,816	0	644	0	68,460
47132	Knox	University of TN Medical Center Home Care Services - HomeHealth*	0	0	0	0	427	5,228	951	4,479	311	0	0	64	0	11,460
AUTHORIZED AGENCIES TOTAL			1,054,102	1,146,119	297,785	2,498,006	117,968	449,959	59,149	285,043	23,051	923,774	0	9,974	13	945,157

Source: TDH HHA Joint Ann. Reports, 2014, pp 6-8

*Agencies enrolled as providers with the Department of Labor

Coalfield Medical Clinic

L&L Community solutions PLLC

March 5, 2015

To Whom It May Concern:

I am writing regarding Frank Smith, born 12-24-1929 and his care through the company, Hero Health. I am a nurse practitioner and have cared for Mr. Smith in 2013 Through May 2014 and from September 16, 2014 until the present time. During this time, he has been under the care of Sharlyn and Hero Health and my assessment is that he receives excellent care. His current medication list and appropriate paper work is always available during his clinic visits. He is always clean and happy when he comes to the clinic. Frank has a good rapport with Sharlyn and Terry, his nurse. They both accompany him to the clinic for his regular visits. He laughs and jokes with them. As you are aware, when a patient reaches their elder years, they become very set in their ways and do not adapt well to change. Frank is no different. He doesn't like change. For example, if for some reason I am out of my office, he refuses to come to see my partner for his health visit. It is important for him to feel safe and confident in his health care providers.

In my professional opinion, it would be very detrimental for his care to be interrupted or to have a change in his caregivers. If you are interested in consistent, quality care for your clients, then I recommend that you continue with Hero Health for providing Frank at home care.

If you have any questions, feel free to contact me at Coalfield Medical Clinic, phone number 865-730-5016 or 17 or fax me at 865-435-6000.

Linda S. Cole, MSN, FNP
Coalfield Medical Clinic
515 Rockbridge Rd.
Oliver Springs, TN 37840

Hero Healthcare, LLC

April 9, 2015

State of Tennessee
Health Services and Development Agency
500 Deaderick Street, 9th Floor
Nashville, Tennessee 37243

Dear Gentlemen and Ladies:

I am the President and sole member of Hero Healthcare, LLC. Hero Healthcare as already paid the majority of the project costs associated with its Application for a Certificate of Need to provide home health services to single resident in Anderson County with a home office in Morgan County and has adequate reserves to provide the remainder of the project costs.

Sincerely,

Sharlyn Young, President

Sharlyn Young
President

Attachment C Economic Feasibility -10

PARSONS & WRIGHT
CERTIFIED PUBLIC ACCOUNTANTS
1000 BRENTWOOD WAY
KINGSTON, TENNESSEE 37763
865-376-5865

ACCOUNTANT'S COMPILATION REPORT

TO THE MEMBERS
HERO HEALTHCARE, LLC
OLIVER SPRINGS, TN

WE HAVE COMPILED THE ACCOMPANYING STATEMENT OF ASSETS, LIABILITIES AND MEMBERS EQUITY-INCOME TAX BASIS OF HERO HEALTH CARE, LLC AS OF DECEMBER 31, 2014, AND THE RELATED STATEMENT OF REVENUES, EXPENSES AND MEMBERS' EQUITY-INCOME TAX BASIS FOR THE PERIODS THEN ENDED. WE HAVE NOT AUDITED OR REVIEWED THE ACCOMPANYING FINANCIAL STATEMENTS AND, ACCORDINGLY, DO NOT EXPRESS AN OPINION OR PROVIDE ANY ASSURANCE ABOUT WHETHER THE FINANCIAL STATEMENTS ARE IN ACCORDANCE WITH THE INCOME TAX BASIS OF ACCOUNTING.

THE MEMBERS ARE RESPONSIBLE FOR THE PREPARATION AND FAIR PRESENTATION OF THE FINANCIAL STATEMENTS IN ACCORDANCE WITH THE INCOME TAX BASIS OF ACCOUNTING AND FOR DESIGNING, IMPLEMENTING, AND MAINTAINING INTERNAL CONTROL RELEVANT TO THE PREPARATION AND FAIR PRESENTATION OF THE FINANCIAL STATEMENTS.

OUR RESPONSIBILITY IS TO CONDUCT THE COMPILATION IN ACCORDANCE WITH STATEMENTS ON STANDARDS FOR ACCOUNTING AND REVIEW SERVICES ISSUED BY THE AMERICAN INSTITUTE OF CERTIFIED PUBLIC ACCOUNTANTS. THE OBJECTIVE OF A COMPILATION IS TO ASSIST THE MEMBERS IN PRESENTING FINANCIAL INFORMATION IN THE FORM OF FINANCIAL STATEMENTS WITHOUT UNDERTAKING TO OBTAIN OR PROVIDE ANY ASSURANCE THAT THERE ARE NO MATERIAL MODIFICATIONS THAT SHOULD BE MADE TO THE FINANCIAL STATEMENTS.

THE MEMBERS HAVE ELECTED TO OMIT SUBSTANTIALLY ALL OF THE DISCLOSURES ORDINARILY INCLUDED IN FINANCIAL STATEMENTS PREPARED IN ACCORDANCE WITH THE INCOME TAX BASIS OF ACCOUNTING. IF THE OMITTED DISCLOSURES WERE INCLUDED IN THE FINANCIAL STATEMENTS, THEY MIGHT INFLUENCE THE USER'S CONCLUSIONS ABOUT THE COMPANY'S ASSETS, LIABILITIES, MEMBERS' EQUITY, REVENUES AND EXPENSES. ACCORDINGLY, THE FINANCIAL STATEMENTS ARE NOT DESIGNED FOR THOSE WHO ARE NOT INFORMED ABOUT SUCH MATTERS.

THE ACCOMPANYING FINANCIAL STATEMENTS DO NOT INCLUDE A PROVISION OR LIABILITY FOR FEDERAL INCOME TAXES BECAUSE THE MEMBERS ARE TAXED INDIVIDUALLY ON THEIR SHARE OF COMPANY EARNINGS.

PARSONS & WRIGHT
FEBRUARY 6, 2015

**HERO HEALTHCARE, LLC
STATEMENT OF ASSETS, LIABILITIES AND MEMBERS EQUITY
INCOME TAX BASIS
DECEMBER 31, 2014**

Assets		2014
Current Assets		
CASH IN BANK		<u>\$ 54,900.54</u>
Total Current Assets		54,900.54
Fixed Assets		
Furniture and Equipment		\$ 786.00
AVD Furniture & Equipment		<u>(786.00)</u>
Total Fixed Assets		0.00
Other Assets		
Total Other Assets		<u>\$ -</u>
Total Assets		<u>\$ 54,900.54</u>

HERO HEALTHCARE, LLC
STATEMENT OF ASSETS, LIABILITIES AND MEMBERS EQUITY
INCOME TAX BASIS
DECEMBER 31, 2014

APR 10 15 39 PM '15

Liabilities and Members Equity

	2014
Current Liabilities	
Federal Income Tax Withheld	\$ 2,655.00
Social Security Taxes Withheld	2,561.86
Medicare Tax Withheld	599.16
Futa Tax Payable	253.87
Suta Tax Payable	<u>905.90</u>
Total Current Liabilities	6,975.79
Long-Term Liabilities	
Total Long-Term Liabilities	\$ <u>-</u>
Total Liabilities	6,975.79
Members Equity	
Sharlyn T. Young, Drawing	\$ (38,578.68)
Sharlyn T. Young, Capital	9,446.54
Net Income	<u>77,056.89</u>
Total Members Equity	<u>47,924.75</u>
Total Liabilities and Members Equity	\$ <u>54,900.54</u>

HERO HEALTHCARE, LLC
STATEMENT OF REVENUE AND EXPENSES
INCOME TAX BASIS
FOR THE TWELVE MONTHS ENDED DECEMBER 31, 2014

	CURRENT PERIOD AMOUNT	CUR PD RATIO	Y-T-D AMOUNT	Y-T-D RATIO
Revenue				
Income	\$ 161,555.85	100.00 %	\$ 223,549.10	100.00 %
Total Revenue	161,555.85	100.00 %	223,549.10	100.00 %
Operating Expenses				
Bill Service Fee	\$ 10,960.00	6.78 %	\$ 10,960.00	4.90 %
Legal and Professional	14,098.33	8.73 %	14,507.28	6.49 %
Contract Labor	840.00	0.52 %	1,085.00	0.49 %
Supplies	1,690.76	1.05 %	1,690.76	0.76 %
Depreciation Expense	786.00	0.49 %	786.00	0.35 %
Insurance Expense	536.37	0.33 %	3,749.37	1.68 %
Insurance - Health	7,712.40	4.77 %	7,712.40	3.45 %
Insurance - Life	427.20	0.26 %	427.20	0.19 %
Workers Compensation Insurance	1,256.00	0.78 %	1,256.00	0.56 %
Interest Expense	0.00	0.00 %	152.63	0.07 %
Office Supplies	1,812.99	1.12 %	2,889.45	1.29 %
Salaries & Wages	69,990.00	43.32 %	90,750.00	40.60 %
Payroll Taxes	6,389.48	3.95 %	8,662.67	3.88 %
Repairs and Maintenance	475.00	0.29 %	625.00	0.28 %
Telephone Expense	312.77	0.19 %	604.54	0.27 %
Utilities	633.91	0.39 %	633.91	0.28 %
Total Operating Expenses	117,921.21	72.99 %	146,492.21	65.53 %
Operating Income (Loss)	43,634.64	27.01 %	77,056.89	34.47 %
Other Income				
Total Other Income	0.00	0.00 %	0.00	0.00 %
Other Expenses				
Total Other Expenses	0.00	0.00 %	0.00	0.00 %
Income (Loss) Before Income Taxes	43,634.64	27.01 %	77,056.89	34.47 %
Income Tax		0.00 %		0.00 %
Net Income (Loss)	\$ 43,634.64	27.01 %	\$ 77,056.89	34.47 %



State of Tennessee

Health Services and Development Agency

Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243

www.tn.gov/hsda

Phone: 615-741-2364

Fax: 615-741-9884

May 1, 2015

Anne Arney, Esq.
Bone Mcallester Norton, PLLC
511 Union Street Suite 1600
Nashville, TN 37219

RE: Certificate of Need Application -- Hero Healthcare - CN1504-012

To establish a home health agency licensed in Anderson and Morgan counties restricted to home health services to a specific patient who is a beneficiary of the United States Department of Labor, Division of Energy Employees Occupation Illness Compensation Program (EEOICP). The principle office will be located at 231 Walls Hollow Road, Oliver Springs (Morgan County), Tennessee. The service area is Morgan and Anderson Counties. The estimated project cost is \$29,680.

Dear Ms. Arney:

This is to acknowledge the receipt of supplemental information to your application for a Certificate of Need. Please be advised that your application is now considered to be complete by this office.

Your application is being forwarded to Trent Sansing at the Tennessee Department of Health for Certificate of Need review by the Division of Policy, Planning and Assessment. You may be contacted by Mr. Sansing or someone from his office for additional clarification while the application is under review by the Department. Mr. Sansing's contact information is Trent.Sansing@tn.gov or 615-253-4702.

In accordance with Tennessee Code Annotated, §68-11-1601, et seq., as amended by Public Chapter 780, the 60-day review cycle for this project will begin on May 1, 2015. The first sixty (60) days of the cycle are assigned to the Department of Health, during which time a public hearing may be held on your application. You will be contacted by a representative from this Agency to establish the date, time and place of the hearing should one be requested. At the end of the sixty (60) day period, a written report from the Department of Health or its representative will be forwarded to this office for Agency review within the thirty (30)-day period immediately following. You will receive a copy of their findings. The Health Services and Development Agency will review your application on July 22, 2015.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. § 68-11-1607(d):

- (1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.
- (2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have questions or require additional information, please contact me.

Sincerely,



Melanie M. Hill
Executive Director

cc: Trent Sansing, TDH/Health Statistics, PPA



State of Tennessee
Health Services and Development Agency

Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

MEMORANDUM

TO: Trent Sansing, CON Director
Office of Policy, Planning and Assessment
Division of Health Statistics
Andrew Johnson Tower, 2nd Floor
710 James Robertson Parkway
Nashville, Tennessee 37243

FROM: Melanie M. Hill
Executive Director

DATE: May 1, 2015

RE: Certificate of Need Application
Hero Healthcare - CN1504-012

Please find enclosed an application for a Certificate of Need for the above-referenced project.

This application has undergone initial review by this office and has been deemed complete. It is being forwarded to your agency for a sixty (60) day review period to begin on May 1, 2015 and end on July 1, 2015.

Should there be any questions regarding this application or the review cycle, please contact this office.

Enclosure

cc: Anne Arney, Esq.



**State of Tennessee
Health Services and Development Agency**

Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

www.tn.gov/hsda

Phone: 615-741-2364

Fax: 615-741-9884

APR 7 15 02:14

LETTER OF INTENT

The Publication of Intent is to be published in the Knoxville News Sentinel which is a newspaper
(Name of Newspaper)
of general circulation in Anderson and Morgan County, Tennessee, on or before April 7, 2015,
(County) (Month / day) (Year)
for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that:

Hero Healthcare LLC N/A
(Name of Applicant) (Facility Type-Existing)

owned by: Hero Healthcare, LLC with Sharlyn Young as sole member with an ownership type of limited liability company

and to be managed by: self-managed intends to file an application for a Certificate of Need
for [PROJECT DESCRIPTION BEGINS HERE]: to establish a home health agency in Anderson and Morgan counties restricted to provide home health care services to a specific patient in Anderson County, at a project cost estimated at \$28,000.00. Its principal office will be located at 231 Walls Hollow Road, Oliver Springs, Morgan County, Tennessee 37840. Therefore, the Applicant is seeking a Certificate of Need for both Anderson and Morgan counties. At this time, the Applicant holds no existing license but will seek to be licensed as a home health agency by the Board of Licensing Health Care Facilities.

The anticipated date of filing the application is: April 10, 2015

The contact person for this project is Anne Sumpter Arney Attorney
(Contact Name) (Title)

who may be reached at: Bone McAllester Norton PLLC 511 Union Street, Suite 1600
(Company Name) (Address)

Nashville TN 37219 615 / 238-6300
(City) (State) (Zip Code) (Area Code / Phone Number)

Anne Sumpter Arney 4/7/2015 asarney@bonelaw.com
(Signature) (Date) (E-mail Address)

The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

**Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243**

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.



State of Tennessee
Health Services and Development Agency

Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

APR 7 15 PM 2:14

PUBLICATION OF INTENT

The following shall be published in the "Legal Notices" section of the newspaper in a space no smaller than two (2) columns by two (2) inches.

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that:

Hero Healthcare LLC, N/A
(Name of Applicant) (Facility Type-Existing)

owned by: Hero Healthcare, LLC with Sharlyn Young as sole member with an ownership type of limited liability company

and to be managed by: self-managed intends to file an application for a Certificate of Need

for [PROJECT DESCRIPTION BEGINS HERE]: to establish a home health agency in Anderson and Morgan counties but restricted to provide home health care services to a single patient in Anderson County, at project cost estimated at \$28,000.00. Its principal office will be located

at 231 Walls Hollow Road, Oliver Springs, Morgan County, Tennessee 37840. Therefore, the Applicant is seeking a Certificate of Need for both Anderson and Morgan counties. At this time, the Applicant holds no existing license but will seek to be licensed as a home health agency by the Board for Licensing Health Care Facilities.

The anticipated date of filing the application is: April 10, 2015

The contact person for this project is Anne Sumpter Arney Attorney
(Contact Name) (Title)

who may be reached at: Bone McAllester Norton PLLC 511 Union Street, Suite 1600
(Company Name) (Address)
Nashville TN 37219 615 / 238-6300
(City) (State) (Zip Code) (Area Code / Phone Number)

Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

Copy
SUPPLEMENTAL
- #1

Hero Healthcare, LLC

CN1504-012

April 22, 2015
10:30am

Anne Sumpter Arney
615.238-6360 Phone
615.687.2764 Fax
asarney@bonelaw.com

April 22, 2015

Mr. Phillip Earhart
HSD Examiner
Health Services and Development Agency
Andrew Jackson Building, 9th Floor
Nashville, TN 37242

**Re: *Certificate of Need Application CN1504-012
Hero Healthcare, LLC***

Dear Phillip:

The responses below are to reply to your letter dated April 15, 2015. This letter is being submitted in triplicate.

1. Section A, Applicant Profile, Item 6

The 5 year lease is noted. However, the lease lists the location of the property as 231 Wallis Hollow Road rather than 231 Walls Hollow Road. Please clarify.

Response: The address in the lease was mistyped. The correct address is 231 Walls Hollow Road. I have enclosed a corrected lease marked as Attachment A Applicant Profile, Item 6.

2. Section B, Project Description, Item I

- A) Please provide a description of the duties, functions and tasks which the applicant intends to perform as part of "home health nursing services".

Response: Applicant intends to perform home health nursing services for Patient X in accordance with his physician's plan of care approved by the EEOICP which includes 24 hours 7 days per week of skilled nursing care and 8 hours a month of case management services. Patient X is blind, elderly, with various cancer diagnoses and a deteriorating condition. The Applicant is required by EEOICP to

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submit daily chart notes documenting his care and health status. The skilled nursing care he requires includes the following:

- (i) Head to toe assessment every shift to include: respiratory status, cardiovascular status, musculoskeletal status, GI/GU status, integumentary status, neurological status, endocrine nutritional/ hydration status, immune status, and mental status.
- (ii) Assessment of vital signs every shift and PRN and report abnormalities to physician.
- (iii) Administer medications as ordered by physician and assess medication compliance, actions, side effects and /or adverse reactions, and desired reaction.
- (iv) Measure intake and output every shift and colostomy care
- (v) Assess patient's pain every shift and PRN and administer pain medication per physician orders.
- (vi) Document interventions and patients response.
- (vii) Assess changes in neurological status every shift.
- (viii) Assess compliance with low sodium, reduced fat, and low calorie diet. Implement and instruct in standard precautions/infection control measures.
- (ix) Assess acclivity intolerance related to numbness and decreased activity as evidenced by complaints of fatigue, overwhelming lack of energy, inability to maintain usual routine, decreased performance, dyspnea, lethargy.
- (x) Assess knowledge deficit related to covered condition as evidenced by: lack of information regarding the pathophysiology, lack of knowledge of medication regimen lack of knowledge of treatment.

B) Please clarify if the proposed home health agency administrator will meet the home health administrator criteria as prescribed by the Rules of the Tennessee Department of Health, Board of Licensing, Chapter 1200-08-26. Please provide an outline of the DOH home health administrator criteria and a copy of the employee's resume.

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Response: Yes, if approved Kristie L. Sims-Straut, RN has agreed to serve as the home health administrator for the Applicant. She will meet the following home health administrator criteria:

“Is a registered nurse with at least one (1) year supervisory or administrative experience in home health care, hospice care or related health programs; “

A copy of her resume is attached as Attachment B Project Description Item I. If Ms. Sims-Straut is not approved as a home health administrator for the Applicant, the Applicant believes it will be able to find another individual to serve as home health administrator without incurring additional cost or time.

- C) Please discuss how the applicant intends to develop, manage, supervise and maintain patient's plans of care.

Response: Patient X's plan of care is provided by his primary physician and approved by EEOICP. The Applicant will employ 4 LPN's and contract with one RN to supervise and maintain his care. The LPN's will work in 12 hour shifts which rotate throughout the week. The RN will provide at least 8 hours per month of case management and nursing supervision. As an EEOICP provider, the Applicant is required to file daily reports of Patient X's care and medical status with the DOE.

- D) How does the applicant intend to implement the proposed home health agency's quality of care plan?

Response: The Applicant will with the assistance of the RN case manager continue to monitor the quality of Patient's care by visits to his home at least weekly. In addition, the Applicant will require daily reports of all nurses providing his care and immediately follow up and resolve any quality issues.

- E) Please provide a brief description of the owner's expertise in starting and managing a home health agency. Brief bio's outlining areas of expertise and experience would be helpful.

Response. The sole owner of the Applicant is a licensed practical nurse with over ten years' experience. She is CPR and AED Certified. The Applicant's owner has worked in both a hospital and home health setting. The owner's experience is adequate to administer the care of a single patient and to manage a home health agency whose services are limited to

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the care of only one patient. Since August 3, 2014, the Applicant has been providing care to Patient X of excellent quality as supported by letters from Patient X, his family and his healthcare providers. The Applicant has been well managed by the owner as evidenced by excellent patient care, well paid staff and a financially sound business. In addition, an administrator will assist the owner with any required aspects of home health agency management that are not within the owner's expertise and experience.

- F) Would the applicant accept a condition on the CON limiting service to this one patient?

Response: Yes. The Applicant only seeks a Certificate of Need limited to providing services to Patient X.

- G) Who is currently serving this patient? If the applicant, does the applicant have some type of waiver from DOH?

Response: The Applicant has been serving Patient X since August of 2014. In January of 2015, the Applicant was advised by the Department of Health that it must seek a Certificate of Need and become licensed as a home health agency in order to continue to provide care to Patient X. The Applicant has advised the Department of Health of this Application and its intent to seek licensure as a home health agency. No action is being taken by the Department of Health while the Applicant is in the process of seeking a Certificate of Need and a home health licensee. The Applicant periodically updates the Department of Health on the status of this Application.

3. Section B, Project Description, Item II A.

Why did patient "X" seek out the applicant to provide his care?

Response: Patient X and his family were concerned that Patient X was not receiving adequate care from his previous home health provider. Patient X believed the caregivers were not adequately monitored and sometimes they failed to make required visits. Patient X knew the owner of the Applicant. She had previously provided nursing services to Patient X and Patient X knew he could count on her to ensure that he received the care he needed and to which he was entitled.

It is noted the applicant began providing services to Patient "X" in September 2014 and billing for services.

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Please clarify which home health agency provided services to Patient "X" prior to September 2014.

Response: The Applicant wishes to correct the Application to state that it began providing services in August of 2014. Prior to August 2014, the Applicant believes Patient X was provided services first by Freedom Healthcare and later by Sunbelt Homecare. However, only Patient X or the previous agency can confirm which agency provided his care.

Please clarify if the applicant has provided direct care home health services to Patient "X" prior to September 2014. If so, please discuss.

Response: The Applicant wishes to correct the Application to say that it began providing services to Patient X in August rather than September of 2014. The Applicant did not provide services to Patient X prior to August of 2014. The Applicant's owner provided nursing services to Patient X prior to August of 2014 as a licensed nurse through another home health agency.

4. Section B, Project Description, Item III (Plot Plan)

As required in the application for all projects, the Plot Plan must provide **the size of the site (in acres), location of the structure on the site, the location of the proposed project (location of the HHA), and the names of streets, roads, highways that cross or border the site.** Please provide a Plot Plan with all the required information.

Response: A copy of the Plot Plan is attached at Attachment B Project Description Item III.

5. Section B, Project Description, Item IV (Floor Plan)

Please provide a floor plan on an 8 ½' x 11" sheet of plain white paper as requested in the application.

Response: A copy of the Floor Plan of the Applicant's home showing the location of the home office is attached as Attachment B Project Description Item IV.

6. Section C, Need, Item 1.

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The letter in Attachment C Need-1 (1) is noted. However, for confidentiality purposes a replacement letter needs to be submitted that redacts, "Patient Name X's name and Family".

Response: A redacted letter is enclosed and marked as Attachment C Need-1.

7. Section C, Need, Item 1.a. (Project Specific Criteria-Home Health Services) (1.-4.)

Guidelines for Growth Methodology: Because the scope of the project includes the creation of an HHA, the applicant must include all existing licensed HHAs authorized to serve the Anderson and Morgan service area in order to apply the need formula correctly. This can be done using the following table (*please note that utilization is requested for three JAR reporting periods.*

Existing Licensed HHAS & Their Utilization serving the 2-County Declared Service Area

Agency License #	Date Licensed	County of Parent Office	Agency Name	2012 JAR Total Patients Served	2013 JAR Total Patients Served	2014 JAR Total Patients Served
150	8/2/1984	Knox	Amedisys Home Health Care	1,097	1,050	764
91	12/13/1982	Hamblen	Amedisys Home Health Care	0	0	0
191	1/17/1984	Overton	Amedisys Tennessee, LLC.	21	31	27
213	6/6/1984	Blount	Blount Memorial Hospital Home Health Services	0	0	0
144	9/7/1978	Knox	Camellia Home Health of East Tennessee	228	108	80
131	8/21/1989	Knox	CareAll Home Care Services	0	9	38
1	10/26/1976	Anderson	Clinch River Home Health	229	242	260
133	7/14/1978	Knox	Covenant Homecare	738	695	870
132	9/13/1984	Knox	East Tennessee Children's Hospital Home Health Care	51	61	48
42	7/17/1984	Davidson	Elk Valley Health Services LLC	8	7	4
211	9/20/1985	Scott	Elk Valley Home Health Care Agency, LLC	11	13	33
142	11/28/1977	Knox	Gentiva Health Services	32	47	22
149	8/15/1984	Knox	Girling Health Care, Inc.	84	144	126
14	3/14/1984	Bradley	Home Health Care of East Tennessee, Inc.	20	9	4
56	09/07/1988	Davidson	LHC HomeCare of Tennessee, LLC dba Home Care Solutions	19	28	34
148	12/13/1984	Knox	Home Option by Harden Health Care	0	14	31
190	9/10/1984	Monroe	Intrepid USA Healthcare Services	13	14	9
2	6/20/1984	Knox	Maxim Healthcare Services, Inc.	21	28	20
143	06/10/1977	Knox	NHC Homecare	157	142	175
208	5/17/1976	Rutherford	NHC Homecare	1	2	2
10	5/16/1984	Hamblen	Premier Support Services, Inc.	1	1	1
620	1/30/2008	Anderson	Professional Case Management of Tennessee	74	52	57
287	3/7/1984	Fentress	Quality Home Health	350	289	330
80	10/28/1983	Fentress	Quality Private Duty Care	23	35	53
16	8/10/1984	Campbell	Sunbelt Homecare	22	8	11
151	2/29/1980	Knox	Tennova Home Health	149	183	149
156	7/20/1983	Knox	University of TN Medical Center Home Care Services – Home Health	168	153	168
TOTALS				3,517	3,365	3,316

Source: TDH HHA Joint Ann. Reports, 2012-2014

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The next step regarding the need formula for home health services (Items 1-4) is to collate the data and show your work using the chart that follows:

Home Health Need Formula in the Applicant's 2-County additional Service Area

County (A)	# Authorized Agencies (B)	2015 Pop (C)	Patients served (2014) (D)	Use Rate (Patient /1000 pop.) (E)	2019 Pop (F)	Projected Capacity (G)	Projected Need (H)	Additional Need (Surplus) for 2017 (G-H)
Anderson	21	76,949	2,790	3.63%	78,123	2,833	1,172	1,661
Morgan	18	21,870	526	2.41%	22,076	531	331	200
Total	39	98,819	3,316	3.36%	100,199	3,362	1,503	1,859

Based on the revised need formula, please discuss why the applicant feels there is a need for an additional home health service agency at this time.

Response: The Applicant does not believe that the statistical analyses of the charts above reflect the need for its services to Patient X. The Applicant is seeking to obtain a license as a Home Health Agency limited to the care of Patient X which will be limited to his lifetime. The Applicant is already an approved EEOICP provider and the Applicant's services will not affect the need or surplus of care in the Service Area; however, the Applicant's services meet a very important need for Patient X. A change in Patient X's caregivers will be a difficult and needless disruption to Patient X in the last years of his life. In order to continue to deliver the level of care required by Patient X, Hero has been advised by the Tennessee Department of Health that it must obtain a CON and be licensed as a home health agency. If granted a CON and a home health license, Hero will be able to meet the needs of Patient X for quality in-home 24/7 nursing care by licensed nurses whom he trusts. Because Hero seeks a limited license restricted to the care of Patient X, Hero's services will not have a significant impact on home health need or capacity in Anderson County and Hero will not provide services in Morgan County.

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8. Section C. Need, Item 1 (Specific Criteria: Home Health Services, Item 5 – Documentation of Referral Sources)

Please address the following home health criterion:

Letters:

5 (a) The applicant shall provide letters of intent from physicians and other referral sources pertaining to patient referral.

Response: A letter from Timothy Bell, D.O is attached as Attachment C Need, Item 1.

5 (c) The applicant shall provide letters from potential patients or providers in the proposed service area that state they have attempted to find appropriate home health services but have not been able to secure such services.

Response: A letter from Patient X is attached as Attachment C Need Item 1.

Other

5 (b) The applicant shall provide information indicating the types of cases physicians would refer to the proposed home health agency and the projected number of cases by service category to be provided in the initial year of operation.

Response: The only case that the Applicant will seek to have referred to the proposed home health agency is Patient X which is 24/7 nursing care with 8 hours of case management.

5 (d) The applicant shall provide information concerning whether a proposed agency would provide services different from those services offered by existing agencies.

Response: The proposed agency would be unique in that it would provide care to a single patient who is an EEOICP beneficiary. As a result its services are focused on the needs of the single patient. In addition, because the agency will only have one patient the owner of the Applicant is able to devote significant time to monitoring the quality of his care.

9. Section C. Need, Item 1 (Specific Criteria: Home Health Services)- Item 6a and 6b

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Please address the following home health criterion:

A) The average cost per visit by service category shall be listed.

Response : The Applicant will only provide nursing services and the EEOICP program reimburses nursing services on an hourly and not a per visit amount. The Applicant will be reimbursed \$74.30 an hour. Assuming that each visit is a 12 hour shift, based on the Applicant's Projected Data Chart, the average cost per visit for nursing care will be approximately \$641.80.

B) The average cost per patient based upon the projected number of visits per patient shall be listed

Response: The only patient cost will be only for Patient X and the Applicant projects that it will provide care for 365 days a year. Based on this assumption, the cost of his care based on the Applicant's Projected Data Chart will be \$468,484 per year.

10. Section C, Need, Item 4.A. and 4.B.

The demographic chart included as Attachment C Need 4 A is noted. However, please revise the chart to reflect the current year of 2015 and the projected year of 2019. Also, please add a column for "service area total".

Response: A revised Attachment C Need 4 A is attached.

11. Section C, Need, Item 5

Please list the existing home health providers that are already certified as EEOICP home health providers in Anderson and Morgan Counties.

Response: A list of the EEOICP home health providers in Anderson and Morgan Counties is enclosed with this letter as Attachment C Need Item 5.

12. Section C. Economic Feasibility Item 1 (Project Cost Chart)

There appears to be a typo under the Legal, Administrative, and Consultant Line. Please revise and submit a replacement page.

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Response: A revised Project Cost Chart is attached. In addition to correcting the typo, the initial license fee of \$1,080 is added for a total Project Cost of \$29,080.

Please account for leased space in the Project Cost Chart.

Response: The lease is paid annually in arrears and is due and payable whether or not this Application is successful. It is not part of the Project Cost. It is included as part of the Projected Data Chart

Where has office furniture, fax machines, computers, etc. been accounted for in the Project Costs Chart?

Response: The Applicant will not need to acquire additional furniture, machines or computers to provide home health services to Patient X so there will be no additional Project Cost Chart.

13. Section C. Economic Feasibility Item 2 (Funding)

The letter from the applicant attesting to the availability of cash to fund the proposed project is noted. However, please provide a letter from a bank that attests to the availability of cash reserves to fund the project.

Response: A Letter from Citizens Bank, Oliver Springs, is attached as Attachment C Economic Feasibility Item 2

14. Section C. Economic Feasibility Item 4. (Projected Data Chart)

- Please indicate the number of patients (1) to be served in Year 1 and Year 2 on line "A. Utilization Data".

Response: See revised Projected Data Chart.

- Please complete the gross operating revenue lines for 2015 and 2016.

Response: See revised Projected Data Chart.

- Why are there professional fees for \$129,000 and \$410,400? Is the \$410,400 amount a typo?

Response: Yes. See revised Projected Data Chart.

- Since the applicant will be leasing property, why is there not rent or lease expense?

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Response: See revised Projected Data Chart which includes the \$100 per year lease expense.

- Please clarify if the applicant will purchase a medical electronic record keeping software program. If so, where is the cost accounted for in the Projected Data Chart?

Response: The Applicant does not intend to purchase any new software programs.

- Please clarify if provider Liability Insurance is accounted for in the Projected Data Chart.

Response: See revised Projected Data Chart which includes the cost of liability insurance of \$1,875.00 per year under other costs.

- Please clarify if vehicles, maintenance and mileage are accounted for in the Projected Data Chart.

Response: The Applicant's employees are not reimbursed for mileage or vehicle maintenance so it is not included as a projected Data Chart.

- Please clarify if the annual Home Health Licensure fee is accounted for in the Projected Data Chart.

Response: The Home Health Licensure fee of \$1080.00 per year is included under the other expenses in the revised Projected Data Chart.

- Please revise and resubmit the Projected Data Chart.

Response: A revised Projected Data Chart is attached.

15. Section C, Economic Feasibility, Item 5

Please identify the project's average gross charge, average deduction from operating revenue, and average net charge using information from the Projected Data Chart for Year 1 and Year 2 of the proposed project.

Response: The project's gross charge is set by the EEOICP as \$74.30 per hour for nursing care. The Applicant projects the average deduction for operating revenue per hour will be \$53.48.

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16. Section C, Economic Feasibility, Item 8

If there is an unexpected major delay in the payment of claims in Year One, how will the applicant pay employees and sustain services to existing home health patients?

Response: The Applicant has never experienced a delay in payment from EEOICP and believes such a delay is unlikely. A prolonged delay would create a hardship which would have to be managed from the Applicant's reserves.

17. Section C, Economic Feasibility, Item 10

The copy of Hero Healthcare, LLC's Balance Sheet and Income Statement in "Attachment C, Economic Feasibility 10" is noted. However, since the letter from the Certified Public Accountant states financial statements are not audited; please provide a bank letter verifying account balances.

Response: A copy of the letter from the Citizens First Bank, Oliver Springs, Tennessee verifying that the Applicant currently had in excess of \$54,000 in its account at December 31, 2014 is attached at Attachment C Economic Feasibility Item 10

18. Section C, Economic Feasibility, Item 11 a.

In lieu of applying for a Certificate of Need for a home health agency, has the applicant considered working as a contract nurse for an EEOICP home health contracted provider? If not, why?

Response: No, the owner of the Applicant's employment by another home health provider would not address the need to care for Patient X. The Applicant is seeking a CON to provide care limited to Patient X's care. There is no assurance that his needs would be met by another agency whether or not Ms. Young is employed by it. The Applicant does not seek employment. She seeks to meet the needs to care for Patient X.

It is noted the applicant stated "Ms. Young is compensated 60 hours a week of services as an owner and is not compensated as an employee of the applicant". However, please clarify if Ms. Young provides direct care or administrative services.

Response: Ms. Young as the owner of the Applicant provides administrative services and supervises and monitors quality of care. She

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does not provide direct nursing services. It is more accurate to say that Ms. Young is not compensated except through her ownership interest in the Applicant. She spends 60 hours a week providing management and administrative services including visiting Patient X's home to monitor his care.

19. Section C, Orderly Development, Item 3

Please clarify if there will be a Director of Nursing Position.

Response: The Applicant anticipates that Ms. Sims-Straut would act as the director of nursing.

Please provide a copy of the professional credentials of the proposed Medical Director of the proposed home health agency. If this physician is not already on board, please describe how the applicant intends to recruit the qualified medical director and other licensed staff members.

Response: The Applicant does not intend to have a medical director. If a medical director is required by the Department of Health for Licensure, the Applicant believes it will be able to hire a medical director for a single patient agency without incurring significant cost or time

What is a PTE?

Response: PTE is Part time employee.

Please provide the following information:

Position	No. of Full Time Equivalent Employees	1st Year	2 nd Year	Applicant's Planned Salary/Wage Range	Prevailing Wage for this type of employee*
Administrator	1	1	1	\$30/hour	\$21-\$28/hour
Staff RNs	1	1	1	\$30/hour	\$21-\$28/hour
Staff LPNs	4	4	4	\$24-\$26/hour	\$14-\$18/hour
Staff HHA/CNA	0	0	0		
TOTAL	6	6	6		

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*TN Dept. of Labor & Workforce Development

20. Section C, Orderly Development, Item 4

What are the staffing requirements for a home health agency per state licensure?

Response: A home health agency must have a qualified administrator and must provide at least one of the qualifying home health services directly through its employees. Applicant will hire a qualified home health administrator and all of its nursing services will be provided by its employees.

21. Section C, Orderly Development, Item 5

Please verify the applicant has reviewed and understands all licensing requirements as required by the State of Tennessee for medical/clinical staff, e.g., RN requirements, administrator requirements, etc.

Response: The Applicant has reviewed and understands all licensing requirements as required by the State of Tennessee for medical/clinical staff, e.g., RN requirements, administrator requirements, etc.

It appears the applicant is currently employing personnel to provide home health care for patient X. Please clarify if the applicant conducted license verification, credentialing, and background checks of existing employees prior to filing this application.

Response: The Applicant conducts back ground checks and licensure checks on all employees before they are hired. The Applicant's employees do not have to be credentialed with a hospital or health insurer because the Applicant's services are not paid by any payor entity other than EEOICP.

22. Section C., Contribution to Orderly Development, Item 8 and 9

The applicant has responded "not applicable" to items 8 and 9. Please provide a clearer response.

Response: The Applicant's response to both Item 8 and 9 is none.

23. Project Completion Forecast Chart

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The agency decision in the Project Completion Chart is July 22, 2015. Does the applicant expect to be licensed between July 22, 2015 and the end of the month? If not, please revise the Project Completion Forecast Chart.

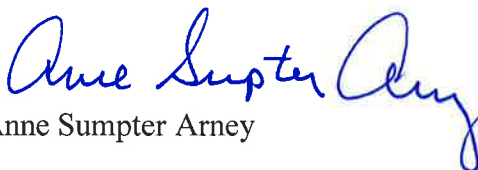
Response: A revised Project Completion Forecast Chart is attached which shows that the Applicant expects to be licensed before September 30, 2015.

In addition, the Applicant's responses in this letter, the Applicant would like to make the following corrections in its Application.

1. The Total Project Costs should be increased to include the initial home health license fee of \$1080 making the total project cost \$29,080 and the RN provides 8 hours of case management a month rather than 4 hours per month. These corrections appear on page 10 and 28 of the Application which is corrected in Exhibit A to this letter.
2. The Applicant began providing services to Patient X in August of 2014 rather than September of 2014. This appears on page 9 of the Application are corrected in Exhibit B to this letter.

Please let me know if you have any further questions for the Applicant in order to deem this Application complete.

Very truly yours,


Anne Sumpter Arney

ASA/s
Enclosures

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STATE OF TENNESSEE

COUNTY OF DavidsonNAME OF FACILITY: Hero Healthcare LLC

I, Anne Supter Arney, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Anne Supter Arney
Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 22nd day of April, 2015,
witness my hand at office in the County of Davidson, State of Tennessee.

Kristie Putman
NOTARY PUBLIC

My commission expires May 3, 2016.

HF-0043

Revised 7/02



Need and Existing Resources

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Through the EEOICP, Congress recognized the need to provide care to former DOE employees such as Patient X through a program that allows them to receive 24/7 nursing care without seeking payment from other federal and state health care programs and with no out of pocket expense to the beneficiary. The DOE has eight active worksites in Oak Ridge, Roane County, Tennessee. Many of the EEOICP beneficiaries are former employees of these sites and live in the areas of Tennessee near Oak Ridge. As a result, the Applicant believes that the need to provide the comprehensive services that are a benefit of EEOICP is greater than other areas of Tennessee. The Applicant's proposed principal service area of Anderson County is adjacent to Roane County and although in 2014, there were 21 other home health agencies who reported serving patients in Anderson County and 21 in Morgan County, to the Applicant's knowledge only 11 of them are contracted to provide services under EEOICP in Anderson County and 8 of them are EEOICP providers in Morgan County. EEOICP provides an important and earned benefit to former federal energy employees and contractors. There is a need for home health agencies that can provide all of the services required by the EEOICP beneficiaries.

Hero has been caring for Patient X as an EEOICP contract nurse and although the Applicant has only one patient, it has been advised by the Department of Health that in order to continue to provide the EEOICP contracted services Hero must obtain a CON and become a licensed home care organization. The care provided by Hero is substantially different from the most home health agencies because its services are comprehensive and include both nursing and home maker services. As a result, Hero is able to provide Patient X all of his required care in his home. Patient X has limited family support and the level of services provided by the Applicant could not be provided by an agency which was not dedicated to the care of single patient. Because the Applicant serves only Patient X, it is able to provide a level of 24/7 care in his home that is necessary for his chronic long term nursing needs. A change in his care at the end of his life will not be in the best interest of his physical or mental health. Patient X's primary care provider has submitted a letter in support of this Application. It is the Applicant's position that the services are not only needed but essential to Patient X as an EEOICP beneficiary. In addition, if Hero is granted a CON, there will be no negative competitive impact on existing resources because the services will be limited to one patient and therefore, limited to the duration of his life. If granted CON approval, Hero is immediately able to provide 24 hour care to Patient X.

Project Costs, Funding and Financial Feasibility

The only cost associated with this project is \$29,080 which is the cost incurred in preparing and filing this Application. The project costs will be funded from the cash reserves of the Applicant. The project cost is reasonable and will not require any capital expenditures.

Staffing

In addition to Ms. Young who is not paid a salary but is compensated as the owner of Hero, the Applicant has 3 FTE and 1 part time employee. All of whom are LPNs and work in 12 hour shifts. In addition, Hero contracts with a registered nurse to provide services for 8 hours a month.

- II. Provide a detailed narrative of the project by addressing the following items as they relate to the proposal.
 - A. Describe the construction, modification and/or renovation of the facility (exclusive of major medical equipment covered by T.C.A. § 68-11-1601 et seq.) including square footage, major operational areas, room configuration, etc. Applicants with hospital

Response: Hero considered the alternative of discontinuing care to Patient X but did not believe it was in the best interest of his physical and mental health. No other alternative was available for the Applicant to continue to provide care to Patient X.

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CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

1. List all existing health care providers (e.g., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, e.g., transfer agreements, contractual agreements for health services.

Response: Hero is a contracted provider under EEOICP. In addition, Hero contracts with a registered nurse to provide certain of the nursing services. Hero has no other plans to contract with other health care providers.

2. Describe the positive and/or negative effects of the proposal on the health care system. Please be sure to discuss any instances of duplication or competition arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.

Response: Hero's services are limited to a single patient for the duration of his life. They will have no effect on the utilization rates of existing providers in Anderson or Morgan Counties. No services will be provided in Morgan County. According to the 2014 Joint Annual Reports, there are 2614 patients receiving home health services in Anderson County and 490 patients receiving home health services in Morgan County. One patient is less than .04 percent of the patients receiving home health services in Anderson County and the limited services provided by the Applicant will have no effect on the health care system in the service area.

3. Provide the current and/or anticipated staffing pattern for all employees providing patient care for the project. This can be reported using FTEs for these positions. Additionally, please compare the clinical staff salaries in the proposal to prevailing wage patterns in the service area as published by the Tennessee Department of Labor & Workforce Development and/or other documented sources.

Response: The Applicant employees 3 FTE LPNS and 1 PTE. All are paid \$26.00 per hour. Hero contracts with a registered nurse to provide 8 hours of care a month at \$30.00 per hour. According to Tennessee Department of Labor and Workforces 2013 Census of Employment and Wages, the average weekly salary in the health care industry was \$830 a week which in a 40 hour week is 20.75 an hour. Based on a 40 hour week, the Applicants FTE's make \$1040 a week which is 20 % higher than the 2013 average for individuals in the health care industry in Anderson county.

4. Discuss the availability of and accessibility to human resources required by the proposal, including adequate professional staff, as per the Department of Health, the Department of Mental Health and Developmental Disabilities, and/or the Division of Mental Retardation Services licensing requirements.

Response: There is adequate staff for Hero to provide services to a single patient in Anderson County.

Discuss any out-of-network relationships in place with MCOs/BHOs in the area.

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NOTE: **Section B** is intended to give the applicant an opportunity to describe the project and to discuss the need that the applicant sees for the project. **Section C** addresses how the project relates to the Certificate of Need criteria of Need, Economic Feasibility, and the Contribution to the Orderly Development of Health Care. **Discussions on how the application relates to the criteria should not take place in this section unless otherwise specified.**

SECTION B: PROJECT DESCRIPTION

I. Provide a brief executive summary of the project not to exceed two pages. Topics to be included in the executive summary are a brief description of proposed services and equipment, ownership structure, service area, need, existing resources, project cost, funding, financial feasibility and staffing.

Response: **Executive Summary of Project**

Proposed Services

Hero Healthcare, LLC ("Hero" or "Applicant") seeks a certificate of need ("CON") for home health services restricted to the care of one fragile elderly resident of Anderson County. ("Patient X"). Patient X is a beneficiary of the United States Department of Labor, Division of Energy Employees Occupation Illness Compensation Program ("EEOICP"). The Energy Employees Occupation Illness Compensation Program was established by Congress to provide compensation and medical benefits to individual who were employed by the Department of Energy ("DOE") and its predecessor agencies who are suffering from illnesses incurred in the performance of their duties for the DOE. Hero is an authorized provider under EEOICP. All compensation for services to Patient X will be paid through Applicant's provider agreement with the DOE. Hero has been providing care to Patient X since August of 2014. Hero is authorized by EEOICP to provide contract nurse services which include but are not limited to the following: 24/7 Skilled nursing care, oxygen therapy, medication administration, and colostomy care and case management by registered nurse. Ms. Young, the sole member of the Applicant, supervises all of Hero's services and is on site with Patient X over 60 hours a week. Although the Applicant provides and seeks to provide services to only one patient, it has been advised by the Tennessee Department of Health that it must seek a license as a home health agency.

Equipment

No medical equipment will be purchased by the Applicant for use in the project.

Ownership

Hero is a Tennessee limited liability company which is wholly owned by Sharlyn Young a Tennessee licensed practical nurse. Ms. Young organized Hero for the sole purpose of providing care to Patient X. Ms. Young supervises all of Hero's services and is on site with Patient X over 60 hours a week.

Service Area

The Applicant seeks a CON to be licensed in both Morgan and Anderson counties because Applicant's business address is in Morgan County; however, the services will be limited to Patient X's address in Anderson County. No services will be provided in Morgan County.

LEASE AGREEMENT

THIS LEASE AGREEMENT (the "Lease"), dated as of August 3, 2014, is by and between Joel G. Scarbrough, a resident of Morgan County, Tennessee ("Lessor"), and Hero Healthcare LLC, a Tennessee limited liability company ("Lessee").

NOW THEREFORE, in consideration of the mutual covenants contained herein, the parties agree as follows:

1. Space, Term. The Lessor agrees to allow the Lessee to use such space as Lessee may reasonably require as a home office for the business operations of Lessee at 321 Walls Hollow road, Oliver Springs, Tennessee (the " "), for the term of five (5) years from the 1st day of September, 2014 to the 1st day of September, 2019 ("Term"). Lessee may terminate this Lease without penalty upon thirty (30) days written notice to Lessor

2. Rent. During the Term of this Lease, Lessee shall pay to Lessor at the address specified below without notice or demand, the rent for the Space (the "Rent"), which shall be payable in arrears annually on the anniversary day of the Term without deduction or offset of any sort. Rent shall be one hundred dollars (\$100) per year. Lessor shall be responsible for all utilities, taxes, maintenance of the Space other than any cost that results in Lessee's breach of this Lease.

3. Default. The happening of any one or more of the following listed events ("Event of Default") shall constitute a breach of this Lease on the part of Lessee:

(a) the failure of Lessee to make the payments of Rent as required herein;

(b) the failure of Lessee materially to comply with any terms or provisions hereof (other than the payment of Rent) after thirty (30) days prior written notice of such default; or

(c) The commencement of any proceeding against Lessee under any bankruptcy or insolvency law, or the appointment of a receiver, levy of execution, attachment, or other taking of any part of the property of Lessee, or any assignment for the benefit of creditors by Lessee.

4. Remedies. Notwithstanding any other provision of this Lease, upon the happening of any Event of Default, and the expiration of any applicable cure period, Lessor may terminate Lessee's right to possession but not terminate the Agreement and/or proceed, by summary proceeding or otherwise and without further notice, reenter the Space either by force or otherwise and dispossess Lessee or any other occupant of the Space, remove their effects, and hold the Space as if this Agreement had not been made, and Lessee hereby waives the service of notice of intention to reenter or to institute legal proceedings to that end. In addition, Lessor may require Lessee or its legal representative(s) to also pay to Lessor any deficiency between the rent and all additional rent hereby reserved and/or agreed to be paid and the net amount, if any, of the rents collected on account of the lease or leases of the Space for each month of the period which would otherwise have constituted the balance of the lease Term

5. Assignment and Subletting. This Lease may not be assigned or sublet by Lessee in any manner whatever.

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5. Termination of Lease or Suspension of Rent in Case of Fire. In case the Space or any part thereof shall at any time during the Term be destroyed or damaged by fire or other unavoidable casualty so as to be unfit for occupancy and use, and so that the Space cannot be rebuilt or restored by the Lessor within one hundred eighty (180) days thereafter, then this Lease shall terminate; but if the Space can be rebuilt or restored within one hundred eighty (180) days the Lessor will at Lessor's own expense and with due diligence so rebuild or restore the Space, and a just and proportionate part of the rents hereby reserved shall be paid by the Lessee until the Space shall have been so rebuilt or restored.

6. Termination of Lease or Suspension of Rent in Case of Taking by Eminent Domain. If the whole or a substantial part of the Space is taken by the city or state or other public authority for any public use, then this Lease shall terminate from the time when possession of the whole or of the part so taken shall be required for such public use, and the rents, properly apportioned, shall be paid up to that time; and the Lessee shall not claim or be entitled to any part of the award to be made for damages for such taking for public use; and such taking shall not be deemed a breach of the Lessor's covenant for quiet enjoyment hereinbefore contained.

7. Entire Agreement. This Lease contains the entire agreement between the parties and cannot be amended unless the amendment is in writing and executed by both parties.

8. Notices. All notices, offers, requests, demands, and other communications pursuant to this Lease shall be given in writing by personal delivery, by prepaid first class registered or certified mail properly addressed with appropriate postage paid thereon, or by telecopier, or facsimile transmission, and shall be deemed to be duly given and received on the date of delivery if delivered personally, on the second day after the deposit in the United States Mail if mailed, or upon acknowledgment of receipt of electronic transmission if sent by telecopier or facsimile transmission. Notices shall be sent to the parties at the following addresses:

If to Lessor:

If to Lessee:

Or to such other address as any party may have furnished to the other in writing in accordance herewith, except that notices of change of address shall only be effective upon receipt.

9. Severability. In the event that any provision of this Lease, or the application thereof to any person or circumstance, is held by a court of competent jurisdiction to be invalid, illegal or unenforceable in any respect in any jurisdiction, such invalidity, illegality or unenforceability shall not affect any other provision of this Lease in that jurisdiction or the application of that provision to any other person or circumstance or in any other jurisdiction, and this Lease shall then be construed in that jurisdiction as if such invalid, illegal or unenforceable provision had not

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been contained in this Lease, but only to the extent of such invalidity, illegality or unenforceability. In the further event of such determination, the parties shall promptly execute and deliver such amendatory provisions to this Lease as are necessary to accomplish lawfully, and as nearly as possible, the goals and purposes of the provision(s) held to be invalid, illegal or unenforceable.

10. Captions and Headings. The section and paragraph captions and headings contained in this Lease are included for reference purposes only and shall not affect in any way the meaning or interpretation of this Lease.

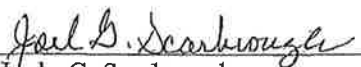
11. Rights Cumulative; No Waiver. No right or remedy herein conferred upon or reserved to either of the parties hereto is intended to be exclusive of any other right or remedy, and each and every right and remedy shall be cumulative and in addition to any other right or remedy given hereunder, or now or hereafter legally existing upon the occurrence of an Event of Default hereunder. The failure of either party to insist at any time upon the strict observance or performance of any of the provisions of this Lease or to exercise any right or remedy as provided in this Lease, shall not impair any such right or remedy or be construed as a waiver or relinquishment thereof with respect to subsequent defaults. Every right and remedy given by this Lease to the parties hereto may be exercised from time to time and as often as may be deemed expedient by the parties, as the case may be.

12. Governing Law; Forum; Service of Process; Venue. This Lease shall be governed by and construed in accordance with the laws of the State of Tennessee. This Lease and its subject matter have substantial contacts with Tennessee, and all actions, suits, or other proceedings with respect to this Lease shall be brought only in a court of competent jurisdiction sitting in Rutherford County, Tennessee, or in the United States District Court having jurisdiction over that County. In any such action, suit, or proceeding, such court shall have personal jurisdiction of all of the parties hereto, and service of process upon them under any applicable statutes, laws, and rules shall be deemed valid and good.

13. Attorney Fees. In the event either party hereto fails to perform any of its obligations under this Lease or in the event a dispute arises concerning the meaning or interpretation of any provision of this Lease, the defaulting party or the party not prevailing in such dispute, as the case may be, shall pay any and all costs and expenses incurred by the other party in enforcing or establishing its rights hereunder, including, without limitation, court costs and reasonable attorney fees.

IN WITNESS WHEREOF, the parties thereto have executed this Agreement as of the date, month and year first above written.

LESSOR:


Joel G. Scarbrough

LESSEE:

**April 22, 2015
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Hero Healthcare, LLC

By: Sharlyn Young, president
Sharlyn Young, president

KRISTIE L. SIMS-STRAUT, RN CASE MANAGER

Overview

RN Case Manager for Department of Labor members and Community and State participants with a broad range of nursing management and assessment skills as well as operational experience in the Tennessee LTC Medicaid and CMS Medicare system since April of 1997. Experience through various nursing leadership positions of increasing responsibility in healthcare, TennCare, Medicare and Commercial operations form the basis of broad understanding of the managed care industry.

Professional Experience

Allcare Plus dba Quality Private Duty Care. Jamestown, Tn.

RN Case Manager-May 2014 to Present

Responsible for evaluations on all new DOL member referrals and management of activities across the continuum of care.

Responsible for Hospice admissions and development of plan of care to meet individual needs through quality and comfort of members life.

Oneida Nursing and Rehab Center (a Grace Health Care Company) – Oneida,Tn.

RN INTERIM DIRECTOR OF NURSING and MDS COORDINATOR– October 2010-May 2014

comprehensive resident assessments; care coordination and planning; resident advocacy and teaching; facilitation of open communication among care team members, the resident, and family; collection and transmission of data for the purposes of quality improvement; and adherence to the Minimum Data Set (MDS) and Resident Assessment Instrument (RAI) requirements. While Interim DON , Responsibilities included: Development and implementation of nursing policy and procedure, overseeing the hiring and continued employment of nursing staff, ensuring there is adequate nursing staff, and that the staff's skills remain current, overseeing nursing employee conduct, being knowledgeable of incidents at the facility, assessing the health needs of each resident and communicating the needs of the residents of the facility to the physicians.

Amedysis Home Health Care, RN Case Manager July 2008-October 2010

Development and Implementation of patient plan of care upon admission through discharge, education of patients and staff, coordination of patient needs and assessments with hands on skills and instruction of such skills to patients and nursing staff providing direct patient care per MD guidelines and orders per policy.

Quality Home Health Care, RN Team Leader April 1997-October 2008

- *Development and Implementation of patient plan of care upon admission through discharge, education of patients and staff, coordination of patient needs and assessments with hands on skills and instruction of such skills to patients and nursing staff providing direct patient care per MD guidelines and orders per policy.*

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Fort Sanders Park West Hospital, RN Charge Nurse October 1989-April 1997

- From 1989-1995 LPN Orthopedic Floor Nurse with all aspects of nursing care to patients including IV therapy, wound care, assessments and education of disease process, medications and ordered treatments.
- From 1995-1997 RN Charge Nurse Orthopedic Unit. Responsible for supervision of nursing staff and patient assignments and assurance of high quality of care by nursing staff through education, staff development and evaluation of nurses providing direct patient care.

Education / Credentials

- Associate Degree Nursing, Roane State Community College, Harriman, Tn. May 1995
- Licensure of Practical Nursing, Oneida Vocational-Technical School, Oneida, Tn. October, 1988-October 1989 with Perfect Attendance Award

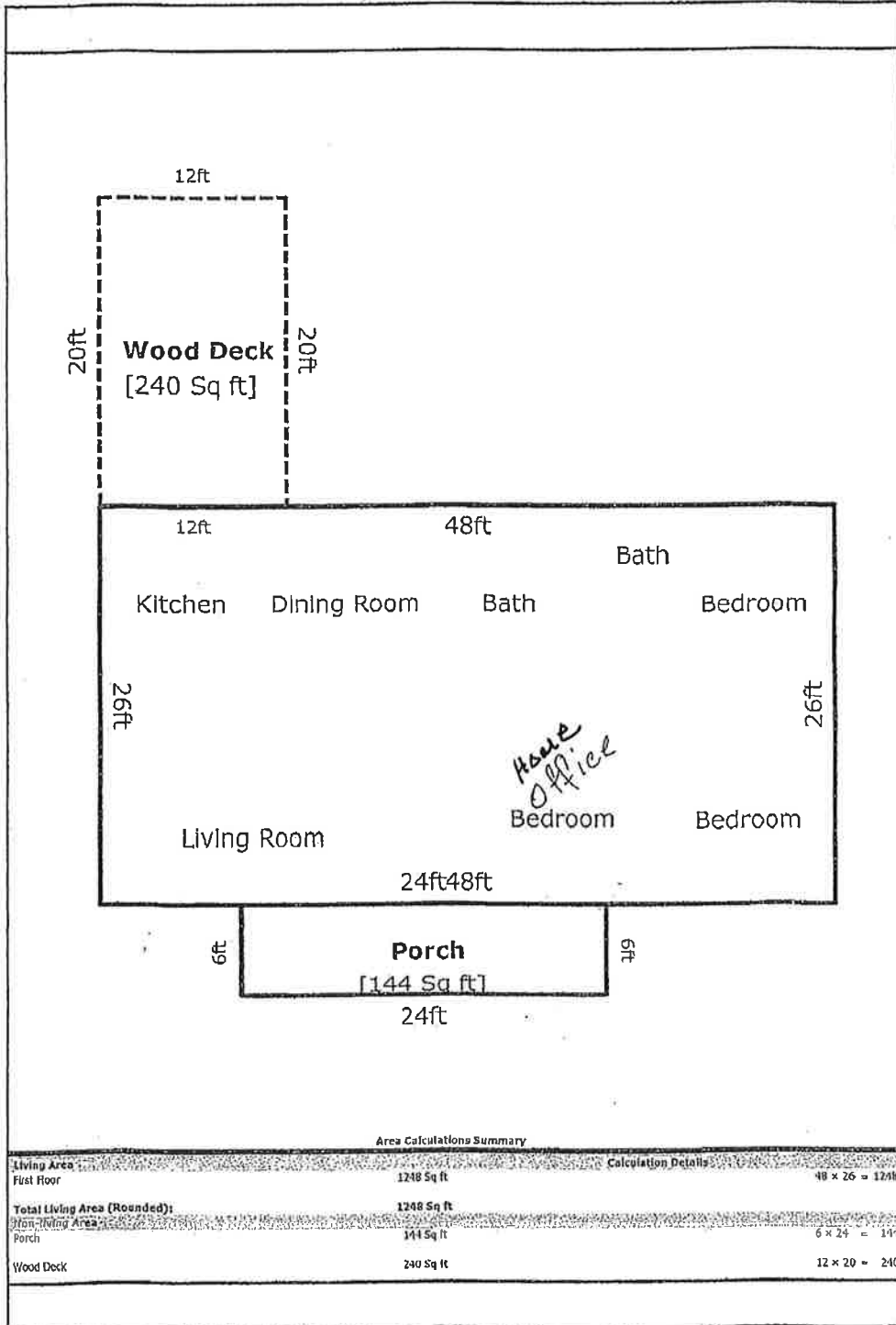


2.04 acres



Building Sketch

Borrower/Client	Joel Scarbrough				
Property Address	231 Walls Hollow Road				
City	Oliver Springs	County	Morgan	State	TN Zip Code 37840-3410
Lender	Crescent Mortgage				



Attachment C Need -1

**April 22, 2015
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April 16, 2015

State of Tennessee
Health Services and Development Agency
500 Deaderick Street, 9th Floor
Nashville, Tennessee 37243

Dear Gentlemen and Ladies:

I am an EEOICP beneficiary living in Anderson County and currently cared for by Hero Health Care, LLC. . I have been unable to find a home health care or other provider who can provide me the level and quality of nursing care that my health requires. I need the services of Hero for home health care services including skilled nursing care.

Very truly yours,

A solid black rectangular box used to redact the signature of the sender.

01/15/2013 10:09 8652701001
Apr. 20. 2015 11:07AM Bone McAllester Norton

SUPPLEMENTAL- 1

PAGE 02/02

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Attachment C Need Item 1


April 16, 2015

State of Tennessee
Health Services and Development Agency
500 Deaderick Street, 9th Floor
Nashville, Tennessee 37243

Dear Gentlemen and Ladies:

The undersigned is the primary care provider of [REDACTED] the EEOICP beneficiary currently cared for by Hero Health Care, LLC. And will refer this patient to Hero for home health care services including skilled nursing care.

Very truly yours,


Timothy E. Bell, DO / Linda Cole, FNP

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Attachment C Need 4 A

Demographic Characteristics of Project Service Area
Hero Healthcare LLC
2015-2019

Demographic	Anderson County	Morgan County	Service Area Total	State of Tennessee
Median Age - 2010 US Census	42.6	39.8	41.2	38
Total Population - 2015	76,949	21,870	98,819	6,649,438
Total Population - 2019	78,123	22,076	100,199	6,894,997
Total Population - % Change 2015 to 2019	1.5%	0.9%	1.4%	1.5%
Age 65+ Population - 2015	14,986	3,531	18,517	1,012,937
% of Total Population	19.5%	16.1%	18.7%	15.2%
Age 65+ Population - 2019	16,737	3,897	20,634	1,134,565
% of Total Population	21.4%	17.7%	20.6%	16.5%
Age 65 + Population - % Change 2015 - 2019	11.7%	10.4%	11.4%	12.0%
Age 18-64 Population - 2015	46,611	14,136	60,747	4,124,968
% of Total Population	60.6%	64.6%	61.5%	62.0%
Age 18-64 Population - 2019	46,577	14,086	60,663	4,228,749
% of Total Population	59.6%	63.8%	60.5%	61.3%
Age 0-17 Population - 2015	15,352	4,203	19,555	1,511,533
% of Total Population	20.0%	19.2%	19.8%	22.7%
Age 0-17 Population - 2019	14,809	4,093	18,902	1,531,683
% of Total Population	19.0%	18.5%	18.9%	22.2%
Age 0-17 Population - % Change 2015 - 2019	-3.5%	-2.6%	-3.3%	1.3%
Median Household Income - 2013	\$40,689.00	\$37,631.00	\$39,160.00	\$44,298.00
TenCare Enrollees (11/14)	15,255	4,531	19,786	1,324,208
Percent of 2014 Population Enrolled in TennCare	19.8%	20.7%	20.0%	19.9%
Persons Below Poverty Level	13,478	3,936	17,414	1,159,611
Persons Below Poverty Level as % of Population (US Census)	17.5%	18.0%	17.6%	17.4%

Source: Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics, U.S. Census QuickFacts, Bureau of TennCare

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Existing Home Health Agencies That Are Certified EEOICP Home Health Providers Within the Project Service Area (Anderson County)			
Alphabetical, By Agency Name			
Health Statistics ID	Agency County	Agency	Type
47202	Knox	Amedisys Home Health Care	Home
05012	Blount	Blount Memorial Hospital Home Health Services	Home
47062	Knox	Camellia Home Health of East Tennessee	Home
01032	Anderson	Clinch River Home Health	Home
47402	Knox	Covenant Homecare	Home
47042	Knox	Gentiva Health Services	Home
47372	Knox	Home Option by Harden Health Care	Home
01042	Anderson	Professional Case Management of Tennessee	Home
07032	Campbell	Sunbelt Homecare	Home
47092	Knox	Tennova Home Health	Home
47132	Knox	University of TN Medical Center Home Care Services – Home Health	Home
		Total	11

Existing Home Health Agencies That Are Certified EEOICP Home Health Providers Within the Project Service Area (Morgan County)			
Alphabetical, By Agency Name			
Health Statistics ID	Agency County	Agency	Type
47202	Knox	Amedisys Home Health Care	Home
47062	Knox	Camellia Home Health of East Tennessee	Home
01032	Anderson	Clinch River Home Health	Home
47402	Knox	Covenant Homecare	Home
01042	Anderson	Professional Case Management of Tennessee	Home
07032	Campbell	Sunbelt Homecare	Home
47092	Knox	Tennova Home Health	Home
47132	Knox	University of TN Medical Center Home Care Services – Home Health	Home
		Total	8

**April 22, 2015
10:30am**

PROJECT COSTS CHART

- A. Construction and equipment acquired by purchase:
1. Architectural and Engineering Fees _____
 2. Legal, Administrative (Excluding CON Filing Fee), Consultant Fees \$25,000
 3. Acquisition of Site _____
 4. Preparation of Site _____
 5. Construction Costs _____
 6. Contingency Fund _____
 7. Fixed Equipment (Not included in Construction Contract) _____
 8. Moveable Equipment (List all equipment over \$50,000) _____
 9. Other (Specify) _____
- B. Acquisition by gift, donation, or lease:
1. Facility (inclusive of building and land) _____
 2. Building only _____
 3. Land only _____
 4. Equipment (Specify) _____
 5. Other (Specify) _____
- C. Financing Costs and Fees:
1. Interim Financing _____
 2. Underwriting Costs _____
 3. Reserve for One Year's Debt Service _____
 4. Other (Specify) Home Health License Fee \$1080
- D. Estimated Project Cost (A+B+C) _____
- E. CON Filing Fee \$3000
- F. Total Estimated Project Cost (D+E)

TOTAL \$29,080

Attachment C Economic Feasibility Item 2

**April 22, 2015
10:30am**



POST OFFICE BOX 1189
WARTBURG, TN 37887
PHONE: (423) 346-2265

April 21, 2015

POST OFFICE BOX 498
OLIVER SPRINGS, TN
37840
PHONE: (865) 435-6655

POST OFFICE BOX 4639
ONEIDA, TN 37841
PHONE: (423) 286-2265

State of Tennessee
Health Services and Development Agency
500 Deadrick Street, 9th Floor
Nashville, Tennessee 37243

POST OFFICE BOX 849
HARRIMAN, TN 37748
PHONE: (865) 882-2265

Dear Gentlemen and Ladies;

POST OFFICE BOX 6348
OAK RIDGE, TN
37831-6348
PHONE: (865) 483-1050

I am Alisa Disney of Citizens First Bank and this letter serves as verification that Hero Healthcare LLC has balances as of April 21, 2015 in excess of \$30,000.00. The balance in this account on December 31, 2014 was \$54,000.00.

Very Truly Yours,

A handwritten signature in cursive script that reads "Alisa Disney".

Alisa Disney
Vice President and Branch Manager
Citizens First Bank

Alisa Disney
Vice President & Branch Manager

ACD/bbm

PROJECTED DATA CHART

SUPPLEMENTAL- 1

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in January (Month). **April 22, 2015 10:30am**

	<u>Year 2016</u> <u>1</u>	<u>Year 2017</u> <u>1</u>
A. Utilization Data (Specify unit of measure)		
B. Revenue from Services to Patients		
1. Inpatient Services	\$ _____	\$ _____
2. Outpatient Services	<u>\$650,868</u>	<u>\$650,868</u>
3. Emergency Services	_____	_____
4. Other Operating Revenue (Specify) _____	_____	_____
Gross Operating Revenue	<u>\$650,868</u>	<u>\$650,868</u>
C. Deductions from Gross Operating Revenue		
1. Contractual Adjustments	\$ _____	\$ _____
2. Provision for Charity Care	_____	_____
3. Provisions for Bad Debt	_____	_____
Total Deductions	\$ _____	\$ _____
NET OPERATING REVENUE	<u>\$650,868</u>	<u>\$650,868</u>
D. Operating Expenses		
1. Salaries and Wages	<u>\$352,516</u>	<u>\$352,516</u>
2. Physician's Salaries and Wages	_____	_____
3. Supplies	<u>\$14,016</u>	<u>\$14,016</u>
4. Taxes	<u>\$25,556</u>	<u>\$25,556</u>
5. Depreciation	_____	_____
6. Rent	<u>\$100</u>	<u>\$100</u>
7. Interest, other than Capital	_____	_____
8. Management Fees:		
a. Fees to Affiliates	_____	_____
b. Fees to Non-Affiliates	_____	_____
9. Other Expenses (Specify) utilities, telephone billing services, license fee, liability insurance, repairs and equipment maintenance	<u>\$76,296</u>	<u>\$76,296</u>
Total Operating Expenses	<u>\$468,484</u>	<u>\$468,484</u>
E. Other Revenue (Expenses) -- Net (Specify)	\$ _____	\$ _____
NET OPERATING INCOME (LOSS)	\$ _____	\$ _____
F. Capital Expenditures		
1. Retirement of Principal	\$ _____	\$ _____
2. Interest	_____	_____
Total Capital Expenditures	\$ _____	\$ _____
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	<u>\$182,384</u>	<u>\$182,384</u>

Attachment C Economic Feasibility Item 10

**April 22, 2015
10:30am**



POST OFFICE BOX 1189
WARTBURG, TN 37887
PHONE: (423) 346-2265

April 21, 2015

POST OFFICE BOX 498
OLIVER SPRINGS, TN
37840
PHONE: (865) 435-6655

POST OFFICE BOX 4639
ONEIDA, TN 37841
PHONE: (423) 286-2265

State of Tennessee
Health Services and Development Agency
500 Deadrick Street, 9th Floor
Nashville, Tennessee 37243

POST OFFICE BOX 849
HARRIMAN, TN 37748
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Dear Gentlemen and Ladies;

POST OFFICE BOX 6348
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I am Alisa Disney of Citizens First Bank and this letter serves as verification that Hero Healthcare LLC has balances as of April 21, 2015 in excess of \$30,000.00. The balance in this account on December 31, 2014 was \$54,000.00.

Very Truly Yours,

A handwritten signature in cursive script that reads "Alisa Disney".

Alisa Disney
Vice President and Branch Manager
Citizens First Bank

Alisa Disney
Vice President & Branch Manager

ACD/bbm

PROJECT COMPLETION FORECAST CHART

SUPPLEMENTAL- 1

**April 22, 2015
10:30am**

Enter the Agency projected Initial Decision date, as published in T.C.A. § 68-11-1609(c): July 22, 2015

Assuming the CON approval becomes the final agency action on that date; indicate the number of days from the above agency decision date to each phase of the completion forecast.

<u>Phase</u>	<u>DAYS REQUIRED</u>	<u>Anticipated Date (MONTH/YEAR)</u>
1. <u>Architectural and engineering contract signed</u>	<u> </u>	<u> </u>
2. <u>Construction documents approved by the Tennessee Department of Health</u>	<u> </u>	<u> </u>
3. <u>Construction contract signed</u>	<u> </u>	<u> </u>
4. <u>Building permit secured</u>	<u> </u>	<u> </u>
5. <u>Site preparation completed</u>	<u> </u>	<u> </u>
6. <u>Building construction commenced</u>	<u> </u>	<u> </u>
7. <u>Construction 40% complete</u>	<u> </u>	<u> </u>
8. <u>Construction 80% complete</u>	<u> </u>	<u> </u>
9. <u>Construction 100% complete (approved for occupancy)</u>	<u> </u>	<u> </u>
10. <u>*Issuance of license</u>		<u>September 30, 2015</u>
11. <u>*Initiation of service</u>		<u>October 1, 2015</u>
12. <u>Final Architectural Certification of Payment</u>	<u> </u>	<u> </u>
13. <u>Final Project Report Form (HF0055)</u>	<u> </u>	<u> </u>

*** For projects that do NOT involve construction or renovation: Please complete items 10 and 11 only.**

Note: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.

Copy
SUPPLEMENTAL
- #2

Hero Healthcare, LLC

CN1504-012

April 28, 2015

Mr. Phillip Earhart
HSD Examiner
State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor
Nashville, Tennessee

Re: Certificate of Need Application CN1504-012
Hero Healthcare, LLC

Dear Mr. Earhart:

The responses below are to reply to your letter dated April 15, 2015. This letter is being submitted in triplicate.

1. Section B, Project Description, *Item I*

On page 10 of the application, the applicant notes there are a number of other agencies providing this same type care in the general area. Why is this proposed agency necessary when there are 11 other home health agencies in Anderson County and 8 in Morgan County that are currently contracted with the EEOICPA to provide this very special type care?

Response: The Applicant does not seek to provide services in Morgan County. Morgan County is included in its service area only because it is the location of its business office. The Applicant will provide services in Anderson County. In Anderson County, according to the 2014 Joint Annual Reports, only three of the EEOICPA approved home health agencies provide services of the 24/7 "private duty" type which are required by Patient X. In addition, the home health agencies who previously served Patient X were unreliable and repeatedly missed visits. This was stressful for Patient X and could have resulted in compromised care. Because the Applicant is dedicated to serving only Patient X, it is able to monitor both the consistency and quality of his care in a way that another agency could not. The Applicant provides services that are needed by Patient X and were not provided by previous agencies.

Ms. Anne Sumpter Arney
April 28, 2015
Page 2

On page 10 of the application, the applicant references the comprehensive services needed by this patient. This applicant proposes to provide only skilled nursing and homemaker services. What kind of comprehensive services can this agency provide that a currently licensed agency cannot? Other agencies will have home health aides, therapy providers and social workers; will the applicant provide these?

Response: The Applicant proposes to provide the services authorized under the EEOICPA plan of care. Those services are 24/7 skilled nursing services and 8 hours a month of case management. The Applicant's services are different from other agencies because they are provided to one patient. The Applicant does not intend to provide homemaker services and will not need to employ home health aids, therapy providers or social workers because these services are not part of Patient X's EEOICPA plan of care. The comprehensive services that Patient X requires are 24/7 skilled nursing services. They are comprehensive in that they are required all of the time.

The applicant's owner notes that she started providing care to this patient in August 2014. In January 2015, the applicant notes she was advised by TDH that a certificate of need and license were required. It appears that even though the applicant was advised of that requirement, she has continued to provide care in violation of this state's certificate of need and licensure laws. Why did the applicant not make arrangements to transfer the patient to a licensed agency contracted with EEOICPA at the time she received the notice? If this CON is not approved, does the applicant intend to still provide the care in violation of the law?

The applicant references conversations with TDH regarding the need to seek a certificate of need and license. Please provide written documentation that TDH has permitted the applicant to continue to operate without the benefit of a license. Please be advised that Tennessee law includes provisions related to enjoining violations as well as for the imposition of civil monetary penalties for performing actions for which a certificate of need is required.

Response: The Applicant believed that providing nursing services to one patient did not require a home health agency license. The Tennessee Department of Health ("DOH") did not agree with that position. I have attached a copy of the Applicant's correspondence from the Tennessee Department of Health and Attachment B Project Description Item 7 in which they advise the Applicant that it will pursue a cease and desist action if the Applicant does not begin the process of becoming licensed as a home health agency within 30 days of the letter. The Applicant's attorney discussed the need with for a Certificate of Need with DOH

Ms. Anne Sumpter Arney
April 28, 2015
Page 3

and was advised that if the Applicant began preparing an Application for a CON within the 30 day period that the Applicant would satisfy the DOH requirement as stated in the January 13, 2015 letter. The Applicant filed its original letter of intent with the Health Services and Development Agency on March 3, 2015 and was advised that it must refile to include Morgan County in its service area. I have attached an email from the DOH confirming that the DOH requirements were still being met at Attachment B Project Description Item 1. The Applicant does not intend to provide care in violation of the law and will take steps required by it to stay in compliance with the law.

2. Section B, Project Description, Item II A.

The response to this question indicates the applicant met the patient that is the subject of this application when she previously provided care for the patient. Who was her employer at that time? If it was a licensed home health agency, didn't the applicant know that it would be unlawful to provide the same care without the benefit of a certificate of need and license. Please clarify and discuss.

Response: The owner of the Applicant was employed by Freedom Care when she met the patient. Unlike any other licensed home health agency including Freedom Care, the Applicant provides care to only one patient. The Applicant was approved as a nursing provider by EEOICPA and did not believe that she needed to seek a license to provide the 24 /7 services to a single patient. See the attached letter to the Department of Health, dated October 31, 2014 which is attached as Attachment B Project Description, Item II A.

3. Section C. Economic Feasibility Item 1 (Project Cost Chart)

There must be an assessment of the space being used as the home office in the Project Cost Chart. It should reflect the fair market value of the space or if applicable the lease cost over the life of the lease, whichever is higher. Also even if applicant has already paid for equipment, the applicant will need to assess the fair market value of the equipment and include it in Project Cost Chart. Any applicable depreciation would need to be included in the Projected Data Chart. Please revise.

Response: A revised Project Cost Chart is attached as Exhibit A (consistent with last page). The Applicant's space is a home office which uses less than 3 square feet. The remaining life of the Applicant's lease will be less than 4 years so the lease cost will be less than \$400. The equipment to be used for the Project consists of a computer and fax machine which were purchased last year for a total cost of \$800. The Applicant estimates

that their combined fair market value is less than \$200. There will be no applicable depreciation so that Projected Data Chart is not revised.

4. Section C. Economic Feasibility Item 4. (Projected Data Chart)

If the applicant has to adjust the staffing chart then salaries may need to be adjusted in the Projected Data Chart. If needed, please provide a revised Projected Data Chart reflecting the revisions.

Response: Although the Applicant hopes that the DOH will approve a license for the Applicant with Ms. Sims-Stuart acting as both the Administrator and the RN Case Manager, the Projected Data Chart already included salaries for a full time administrator and a separate RN case manager in case the Applicant was required to hire two separate professionals for those positions.

Please complete the following chart for Other Expenses:

PROJECTED DATA CHART-OTHER EXPENSES

<u>OTHER EXPENSES CATEGORIES</u>	2016	2017	2018
1. Billing Service Fee	\$ 12,961	\$ 12,961	\$ 12,961
2. Utilities and Telephone Expense	4,500	4,500	4,500
3. Liability Insurance	1,875	1,875	1,875
4. License Fee	1,080	1,080	1080
5. Repairs and Maintenance	2,500	2,500	2,500
6. Other Insurance	38,000	38,000	38,000
7. Professional and Legal	5,000	5,000	5,000
8. Unanticipated Contingencies	10,380	10,380	10,380
Total Other Expenses	\$ 76,296	\$ 76,296	\$ 76,296

5. Section C, Orderly Development, Item 3

The applicant has indicated that the owner, Sharlyn Young, will not be paid staff yet she will be providing management and administrative services on site 60 hours/week. Is it correct that Ms. Young will be providing these services 60 hour/week in the patient's home? If so, please explain the duties of Kristie L. Sims-Stuart, R.N as the home health administrator. That position is listed as full time in the staffing chart. How many hours per week will she be working and what will her duties be?

Response: Ms. Young, as the owner of the Applicant, takes very seriously the level of care that is required by Patient X. She is on site to make sure that there is

Ms. Anne Sumpter Arney
April 28, 2015
Page 5

no gap in service and that the LPN's arrive promptly and stay their entire shift. This allows Patient X not to have any anxiety about the reliability of his care. In addition, Ms. Young monitors the concerns of Patient X about his care. The number hours that will be required are a projection. Ms. Sims-Stuart will be hired to provide the services required of a home health administrator. Although, the exact number of hours are impossible to predict, the Applicant will work with the DOH to determine what hours are required to meet its standards. The Applicant anticipates that these will be less than a typical home health agency since administration should be less time consuming because the Applicant will be serving only one patient. The Administrator will be available by phone during normal working hours. In addition, she will be responsible for all developing and monitoring compliance with procedures and policies required by the DOH and supervision of the LPNs.

Who will be providing the RN case management and supervision? Will that be Ms. Sims-Stuart or a different RN? This position is also listed as 1.0 FTE, yet it has been stated that there will be 8 hours per month of case management services. What will the RN be doing the remaining 152 hours in the month?

Response: Since the Applicant seeks to serve only one patient, the Applicant hopes to employ Ms. Sims-Stuart as both Administrator and Case Manager. If the DOH, does not approve her dual role, the Applicant will seek to contract with another RN to provide case management. If allowed by the DOH, the Applicant would employ an RN to provide the case management and the nursing supervision on an hourly basis which would be less than a full time position. However, the Applicant does not know how much time will be required for nurse supervision but has budgeted it as a $\frac{1}{4}$ full time position in the Projected Data Chart for a cost of \$30 per hour at approximately 25 hours a month with an annual bonus of \$1,000.

Will there be an LPN onsite 24/7 as well as Ms. Young? If so, exactly what services will Ms. Young be providing 60 hours weekly onsite.

Response: Yes, there will be another LPN onsite 24/7 as well as Ms. Young. Ms. Young's only services are to monitor the other LPN's and assure that care is timely and reliable. She does not charge for her services. As the owner of the Applicant, she wants to insure that Patient X does not have any concerns about whether or not the scheduled nurse will arrive on time and provide the care he needs which was an issue with the previous agencies who provided his care.

Ms. Anne Sumpter Arney
April 28, 2015
Page 6

It appears EEOICPA also reimburses for the services of a home health aide to assist with daily living activities such as dressing and feeding, and food preparation. Please clarify the reason the applicant will not employ Home Health Aides?

Response: The Applicant seeks a CON and license to provide care only to Patient X. His plan of care is for skilled nursing services 24/7 and 8 hours of case management and that is all that the Applicant seeks to provide.

Please revise the following table:

Position	No. of Full Time Equivalent Employees	1st Year	Applicant's Planned Salary/Wage Range	Year 1 Total Salaries/Wages as reported in the Projected Data Chart
Administrator	1	1	\$50 ,000	\$50,000
Director of Nursing	1/4 *	1/4*	\$10,000	\$10,000
Staff RNs	**8 hours per month contract labor	**8 hours per month contract labor	\$30 per hour	\$ 2,888
Staff LPNs	4	4	\$26-28 per hour. (plus time and ½ for overtime)***	\$ 302,516
PTE	0	0	NA	NA
Staff HHA/CNA	0	0	NA	NA
TOTAL		5		

*The Applicant anticipates that the Director of Nursing will be a part time position of no more than approximately 25 hours a month

**This position and the director of nursing may also be provided by the Administrator if approved by the DOH

*** The Applicant has estimated the amount of overtime that may be paid to staff LPNs.

6. Section C, Orderly Development, Item 5

Please provide documentation (with effective dates) from the U.S. Department of Labor, Division of Energy Employee Occupational Illness Compensation, that Hero Healthcare, LLC is an enrolled provider.

Ms. Anne Sumpter Arney
April 28, 2015
Page 7

Response: The Applicant's provider enrollment information is attached as Attachment C Orderly Development Item 5.

If the applicant is not an enrolled EEOICPA provider, please provide an overview of how the applicant has been reimbursed for home health services since August 2014.

Response: The Applicant is enrolled as a contract nurse with EEOICPA and has been reimbursed by them for services.

Please provide an overview of the EEOICPA provider credentialing and enrollment process.

Response : Information concerning the EEOICPA enrollment process is attached at Attachment C Orderly Development Item 5.

Please clarify if EEOICPA requires a home health license number as part of their credentialing process.

Response: They did not.

What provider type is the applicant enrolled with the EEOICPA?

Response: Contract Nurse.

In accordance with Tennessee Code Annotated, §68-11-1607(c) (5), "... If an application is not deemed complete within sixty (60) days after written notification is given to the applicant by the agency staff that the application is deemed incomplete, the application shall be deemed void." **For this application the sixtieth (60th) day after written notification is June 15, 2015. If this application is not deemed complete by this date, the application will be deemed void.** Agency Rule 0720-10-.03(4) (d) (2) indicates that "Failure of the applicant to meet this deadline will result in the application being considered withdrawn and returned to the contact person. Re-submittal of the application must be accomplished in accordance with Rule 0720-10-.03 and requires an additional filing fee." Please note that supplemental information must be submitted timely for the application to be deemed complete prior to the beginning date of the review cycle which the applicant intends to enter, even if that time is less than the sixty (60) days allowed by the statute. The supplemental information must be submitted with the enclosed affidavit, which shall be executed and notarized; please attach the notarized affidavit to the supplemental information.

Ms. Anne Sumpter Arney
April 28, 2015
Page 8

If all supplemental information is not received and the application officially deemed complete prior to the beginning of the next review cycle, then consideration of the application could be delayed into a later review cycle. The review cycle for each application shall begin on the first day of the month after the application has been deemed complete by the staff of the Health Services and Development Agency.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. § 68-11-1607(d):

- (1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.
- (2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

In addition, the Applicant's responses in this letter, the Applicant would like to make the following corrections in its Application.

The Total Project Costs should be increased to the total project cost \$29,680. This correction appears on page 10 of the Application and in the revised Project Cost Chart which is corrected in Exhibit A to this letter.

Should you have any questions or require additional information, please do not hesitate to contact this office.

Sincerely,


Anne Sumpter Arney

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF Davidson

NAME OF FACILITY: Hero Healthcare, LLC

I, Anne Sumpter Arvey, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Anne Sumpter Arvey
Signature/Title atty

Sworn to and subscribed before me, a Notary Public, this the 28th day of April, 2015,
witness my hand at office in the County of Davidson, State of Tennessee.

Kristie Putman
NOTARY PUBLIC

My commission expires May 3, 2016

HF-0043

Revised 7/02



APR 28 15:43:08

PROJECT COSTS CHART

A.	Construction and equipment acquired by purchase:	
1.	Architectural and Engineering Fees	
2.	Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	\$25,000
3.	Acquisition of Site	
4.	Preparation of Site	
5.	Construction Costs	
6.	Contingency Fund	
7.	Fixed Equipment (Not included in Construction Contract)	
8.	Moveable Equipment (List all equipment over \$50,000)	\$ 200
B.	Acquisition by gift, donation, or lease:	
1.	Facility (inclusive of building and land)	\$400
2.	Building only	
3.	Land only	
4.	Equipment (Specify) computer and fax	
5.	Other (Specify) _____	
C.	Financing Costs and Fees:	
1.	Interim Financing	
2.	Underwriting Costs	
3.	Reserve for One Year's Debt Service	
4.	Other (Specify) Home Health License Fee	\$1080
D.	Estimated Project Cost (A+B+C)	
E.	CON Filing Fee	\$3000
F.	Total Estimated Project Cost (D+E)	

TOTAL \$29,680

Through the EEOICP, Congress recognized the need to provide care to former DOE employees such as Patient X through a program that allows them to receive 24/7 nursing care without seeking payment from other federal and state health care programs and with no out of pocket expense to the beneficiary. The DOE has eight active worksites in Oak Ridge, Roane County, Tennessee. Many of the EEOICP beneficiaries are former employees of these sites and live in the areas of Tennessee near Oak Ridge. As a result, the Applicant believes that the need to provide the comprehensive services that are a benefit of EEOICP is greater than other areas of Tennessee. The Applicant's proposed principal service area of Anderson County is adjacent to Roane County and although in 2014, there were 21 other home health agencies who reported serving patients in Anderson County and 21 in Morgan County, to the Applicant's knowledge only 11 of them are contracted to provide services under EEOICP in Anderson County and 8 of them are EEOICP providers in Morgan County. EEOICP provides an important and earned benefit to former federal energy employees and contractors. There is a need for home health agencies that can provide all of the services required by the EEOICP beneficiaries.

Hero has been caring for Patient X as an EEOICP contract nurse and although the Applicant has only one patient, it has been advised by the Department of Health that in order to continue to provide the EEOICP contracted services Hero must obtain a CON and become a licensed home care organization. The care provided by Hero is substantially different from the most home health agencies because its services are comprehensive and include both nursing and home maker services. As a result, Hero is able to provide Patient X all of his required care in his home. Patient X has limited family support and the level of services provided by the Applicant could not be provided by an agency which was not dedicated to the care of single patient. Because the Applicant serves only Patient X, it is able to provide a level of 24/7 care in his home that is necessary for his chronic long term nursing needs. A change in his care at the end of his life will not be in the best interest of his physical or mental health. Patient X's primary care provider has submitted a letter in support of this Application. It is the Applicant's position that the services are not only needed but essential to Patient X as an EEOICP beneficiary. In addition, if Hero is granted a CON, there will be no negative competitive impact on existing resources because the services will be limited to one patient and therefore, limited to the duration of his life. If granted CON approval, Hero is immediately able to provide 24 hour care to Patient X.

Project Costs, Funding and Financial Feasibility

The only cost associated with this project is \$29,680 which is the cost incurred in preparing and filing this Application. The project costs will be funded from the cash reserves of the Applicant. The project cost is reasonable and will not require any capital expenditures.

Staffing

In addition to Ms. Young who is not paid a salary but is compensated as the owner of Hero, the Applicant has 3 FTE and 1 part time employee. All of whom are LPNs and work in 12 hour shifts. In addition, Hero contracts with a registered nurse to provide services for 4 hours a month.

- II. Provide a detailed narrative of the project by addressing the following items as they relate to the proposal.
 - A. Describe the construction, modification and/or renovation of the facility (exclusive of major medical equipment covered by T.C.A. § 68-11-1601 et seq.) including square footage, major operational areas, room configuration, etc. Applicants with hospital



**TENNESSEE DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE AND REGULATION
OFFICE OF HEALTH CARE FACILITIES
665 MAINSTREAM DRIVE
SECOND FLOOR
NASHVILLE, TN 37243**

January 12, 2015

Anne Sumpter Arney
Bone, McAllester, Norton PLLC
Nashville City Center, Suite 1600
511 Union Street
Nashville, TN 37219

Dear Ms. Arney:

I am in receipt of your response letter for Sharlyn Young dated October 31, 2014. In this letter, you state that Tennessee Law does not require a home health license or certificate of need to provide services to one patient which is the case for Ms. Young. You have based this conclusion on the T.C.A. § 68-11-201 definition of Home Care Organization which has the term patient contained in the plural. After careful review by the Office of Health Care Facilities' administrative staff and attorney, the plural of patient in the definition of Home Care Organization does not negate the requirement for licensure as a Home Care Organization providing Home Health Services. The scope of service(s) Ms. Young provides to one individual is in the context of the T.C.A. § 68-11-201 definition of Home Health Service which states, "means a service provided an outpatient by an appropriately licensed health care professional or an appropriately qualified staff member of a licensed home care organization in accordance with orders recorded by a physician, that includes one (1) or more of the following: skilled nursing care, including part-time or intermittent supervision;..."

Again, in order to provide these services in the state of Tennessee, you must have a license from the Department of Health. State law, Tenn. Code Ann. § 68-11-204, prohibits a Home Care Organization providing Home Health Services from operating without a license. Ms. Young will first need to obtain a Certificate of Need prior to becoming licensed. You or Ms. Young may contact Health Services Development Agency regarding a Certificate of Need at (615) 741-2364. A copy of the required application with instructions and applicable regulations for operating a Home Care Organization providing Home Health Services can be accessed on our website at <http://health.state.tn.us/HCF/rules.htm>. If you do not have access to the internet or you

need additional assistance in completing the necessary paperwork, please contact the Licensure Unit in the Division of Health Care Facilities' Central Office at (615) 741-7221.

If Ms. Young wishes to become licensed, she must submit an application to the Department within a thirty (30) day time frame. If she does not wish to become licensed, she must immediately cease operations and transfer any resident(s)/patient(s) to other appropriately licensed facilities. Failure to make application for licensure within thirty (30) days will result in the initiation of injunctive relief in the Knox County's Chancery Court and any other relief available in law or equity against any person who owns, operates, manages, or participates in the management of any facility required to be licensed under the Health Facilities and Resources Act. (Tenn. Code Ann. § 68-11-213(a)).

Sincerely,

A handwritten signature in cursive script, appearing to read "Ann R. Reed".

Ann Rutherford Reed, RN, BSN, MBA

Director of Licensure and the Board for Licensing Health Care Facilities

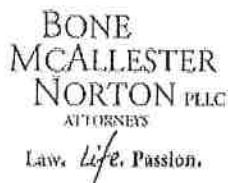
Cc: Vincent L. Davis, Director of Health Care Facilities
Kyonzte Hughes-Toombs, Office of General Counsel
Karen Kirby, Administrator, East Tennessee Regional Office

Anne Sumpter Arney




From: Anne Sumpter Arney
Sent: Monday, March 09, 2015 12:46 PM
To: 'Ann R. Reed'
Subject: RE: Sharlyn Young

Thank you for your continued assistance.

Anne



Anne Sumpter Arney | Attorney
Bone McAllester Norton PLLC
511 Union Street / Suite 1600 / Nashville, TN 37219
tel (615) 238-6360 / fax (615) 687-2764
asarney@bonelaw.com / www.bonelaw.com

Follow Me:   

From: Ann R. Reed [<mailto:Ann.R.Reed@tn.gov>]
Sent: Monday, March 09, 2015 12:44 PM
To: Anne Sumpter Arney
Cc: Mark Farber (mark.farber@state.tn.us)
Subject: RE: Sharlyn Young

Anne

This update of your client's intent to obtain a HHA CON is sufficient to satisfy the request of the cease and desist letter sent previously. Please just keep me updated. Thanks.

Ann Rutherford Reed, RN, BSN, MBA
Director of Licensure
Division of Health Licensure and Regulation
Office of Health Care Facilities
665 Mainstream Drive, 2nd Floor
Nashville, TN. 37243
Office Telephone (615)741-7221
Direct Telephone (615)532-6595
Fax (615)253-8798
ann.r.reed@tn.gov

Connect with TDH on [Facebook](#) and [Twitter@TNDeptofHealth](#)

"The mission of the Tennessee Department of Health is to protect, promote, and improve the health and prosperity of people in Tennessee."

Please consider the environment and print this email only if necessary, if you do print, please recycle.

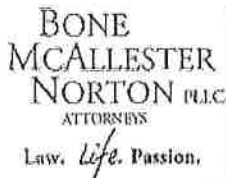
CONFIDENTIALITY NOTICE: The information contained in this email and any attachments is CONFIDENTIAL and may be privileged. If you are not the intended recipient, please destroy this message, delete any copies held in your systems, and notify the sender immediately. You should not retain, copy or use this email for any purpose nor disclose all or any of its content(s) to any other person. We apologize for any inconvenience this may have caused.

From: Anne Sumpter Arney [<mailto:asarney@bonelaw.com>]
Sent: Monday, March 09, 2015 12:12 PM
To: Ann R. Reed
Cc: Mark Farber (mark.farber@state.tn.us)
Subject: RE: Sharlyn Young




Ms. Reed,

I left a voice message but wanted to follow up by e-mail as well. Ms. Young filed her letter of intent on Friday and published on Friday to obtain a CON for Anderson County. Because we listed the company's address as Ms. Young's home which is in Morgan County, Mark Farber has called and said that we will need to be licensed in Morgan County as well. Either way because the address of the Applicant is not the same as the requested Service Area our letter of intent is not correct and we must republish. The deadline for publication for this review period is tomorrow and the paper's deadline has passed. Can we roll to the next review period to fix this problem in our Letter of Intent without violating our representation to the Department of Health?

Anne Arney



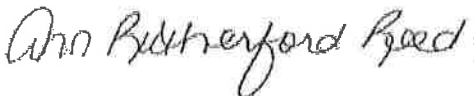
Anne Sumpter Arney | Attorney
Bone McAllester Norton PLLC
511 Union Street / Suite 1600 / Nashville, TN 37219
tel (615) 238-6360 / fax (615) 687-2764
asarney@bonelaw.com / www.bonelaw.com

Follow Me:   

From: Ann R. Reed [<mailto:Ann.R.Reed@tn.gov>]
Sent: Monday, February 02, 2015 8:44 AM
To: Anne Sumpter Arney
Cc: Vincent Davis; Kyonzte Hughes-Toombs
Subject: RE: Sharlyn Young

Anne

Thank you for the follow-up letter. This will be included with the file on Ms. Sharlyn Young.



Ann Rutherford Reed, RN, BSN, MBA
Director of Licensure
Division of Health Licensure and Regulation
Office of Health Care Facilities
665 Mainstream Drive, 2nd Floor
Nashville, TN. 37243
Office Telephone (615)741-7221
Direct Telephone (615)532-6595
Fax (615)253-8798
ann.r.reed@tn.gov

Connect with TDH on [Facebook](#) and [Twitter@TNDeptofHealth!](#)

BONE
MCALLESTER
NORTON ELLC

Anne Sumpter Arney
615.238-6360 Direct Dial
615.687-2764 Direct Fax
asarney@bonelaw.com

October 31, 2014

Via Hand Delivery and E-Mail

Ann Rutherford Reed, RN, BSN, MBA
Director of Licensure and the Board of Licensing Health Care Facilities
Tennessee Department of Health
Division of Health Licensure and Regulation
Office of Health Care Facilities
665 Mainstream Drive
Nashville, Tennessee, 37243

Dear Ms. Reed:

I have been engaged by Ms. Sharlyn Young to respond on her behalf to your letter of October 1, 2014.

Ms. Young is a licensed practical nurse who provides services as a contract nurse to one beneficiary under the United States Department of Labor, Division of Energy Employees Occupation Illness Compensation (EEOIC). The Energy Employees Occupation Illness Compensation Program was established by Congress to provide compensation and medical benefits to individuals who were employed by the Department of Energy ("DOE") and its predecessor agencies who are suffering from illnesses incurred in the performance of their duties for the DOE. All of Ms. Young's compensation for services is paid through her provider agreement with the DOE. She does not receive any compensation from any state health care program.

In your letter of October 1, 2014, you say that Ms. Young may be operating an unlicensed Home Care Organization. Ms. Young is not operating a Home Care Organization and no additional licensure is required. Tenn. Code Ann. § 68-11-201 defines Home Care Organization in part "as providing home health services, home medical equipment services, professional support services or hospice services to patients." Ms. Young is not a Home Care Organization because her services are limited to one patient. She does not provide care to patients. My client provides services to one elderly gentleman in his residence in Anderson County, Tennessee. She does not provide care or arrange for care for anyone else. Ms. Young will not and does not seek to have any other patients. Ms. Young does not now and has never

Ann Rutherford Reed, RN, BSN, MBA
October 31, 2014
Page 2

provided services to more than a single patient. In addition, my client is willing to provide the Department of Health any assurances it may require that she will not provide services to more than the one patient for whom she now cares. My client would welcome the opportunity to meet with representatives of the Department of Health to provide such assurance. The EEOIC beneficiary relies on Ms. Young's services. Ms. Young is dedicated to taking care of this one EEOIC beneficiary through the end of his life but will not provide services to anyone else. Tennessee Law does not require a home health license or a certificate of need to provide services to only one patient.

Please let me know if I or my client can provide any further information to assist you in determining that my client does not require a home health license or a certificate of need.

Sincerely,


Anne Sumpter Arney

ASA/kh

cc: Ms. Sharlyn Young, LPN
Mr. Vincent L. Davis, Director of Health Care Facilities
Kyontze Hughes-Toombs, Esq., Office of General Counsel
Ms. Karen Kirby, Administrator, East Tennessee Regional Office

Dear Provider:

Thank you for your interest in participating as a provider of medical services for programs administered by the U.S. Department of Labor's Office of Workers' Compensation Programs (OWCP). The OWCP administers the Federal Employees' Compensation Act (FECA), the Black Lung Benefits Act (BLBA), and the Energy Employees Occupational Illness Compensation Program Act (EEOICPA).

OWCP has contracted with Affiliated Computer Services (ACS) to provide medical bill processing services to those three programs. As part of their benefit structure, these programs reimburse medical and non-medical providers for services rendered for the care and treatment of a claimant's compensable condition.

To process your bills, each provider must be enrolled with ACS. Please complete the enclosed provider enrollment form so that a provider identification number can be assigned to you. Instructions for completing the enrollment form and a list of provider types and specialty codes are also included.

The Debt Collection Improvement Act of 1996 includes the requirement that payments made by the Federal Government be sent by electronic funds transfer (EFT). EFT payments **are mandatory**, simplify and speed the billing process and reduce the incidence of billing errors. Therefore, an enrollment form for EFT is enclosed. A remittance advice listing all bills paid on each EFT transaction will be sent to your mailing address.

You must submit current licensure information on the completed enrollment application. Moreover you must maintain appropriate current licensure in order to receive payments under our programs. Where large group practices have providers in the group who are not providing medical services to our program on a regular basis, the group practice is responsible for monitoring the licensure of their entire group.

You may register as a participant in any or all three of OWCP's compensation programs. Please be sure to send the completed package(s) to the appropriate program(s) at the address (es) listed on P. 2 of the Form OWCP-1168.

Please be aware that OWCP, in an effort to assist claimants seeking medical services, is now providing an on-line search capability by one or more of the following: specialty, name, city, state, and zip code. The provider look up feature is meant as a customer service feature for those who may be seeking certain medical services in their area. The FECA program provides search capability for physicians enrolled in their program. In addition to physicians, the EEOICPA program is providing a search capability for home health aides and

hospice care. FBLP will include all provider types for the provider look-up with the exception of provider type 53, non-medical vendors from the search. Please advise us in writing when you submit your enrollment application if for some reason you do not wish to be included in this service. Customers using this look-up feature will be advised that this is not an endorsement, referral or an agreement to reimburse for medical services rendered, as the fact that a provider is listed in no way constitutes an endorsement of the provider or that provider's services by the Department of Labor and OWCP. Nor does it guarantee that the medical provider will be reimbursed by OWCP for specific medical services that the provider has billed directly to OWCP or that a medical provider will agree to provide medical services to a particular claimant. The appearance of a specific medical provider's name in the listing of providers in a certain specialty does not require that provider to treat a particular claimant, even if OWCP has already advised the claimant in writing that medical treatment for a particular condition within the provider's listed specialty has been authorized.

You will be notified by mail once your enrollment package has been processed. Once you have received your ACS provider number, you may submit your bills to the appropriate program at the following address:

US Department of Labor
OWCP/FECA
P.O. Box 8300
London, KY 40742-8300

DEEOIC
P.O. Box 8304
London, KY 40742-8304

DCMWC/Black Lung
P.O. Box 8302
London, KY 40742-8302

If you have any questions regarding this information, please contact us at: 1-850-558-1818. Our business hours are Monday through Friday from 8:00 am to 8:00 pm, Eastern Time.

NOTICE: Please be aware that continued participation as a medical provider under the three DOL programs above is contingent on your maintaining good standing as a medical provider under other federal health benefit programs such as Medicare—exclusion as a medical provider in those circumstances operates as an automatic exclusion under the above-entitled programs administered by OWCP. (See e.g. 20 C.F.R. §§ 10.815, 30.715 and 702.431)

Attachment C Orderly Development Item 5

Instructions

A brief description of each data element is listed below. Be sure to sign and date the form when you submit it. For further information contact Affiliated Computer Science or Office of Workers' Compensation Programs at the telephone numbers indicated on the form.

- Block 1 Indicate whether this form is being used for a new enrollment, or to update an existing enrollment record. If the form is being submitted to update your record, enter your Provider Number or Employer Identification Number.
- Block 1a Check all programs in which you want to enroll as a provider.
- Block 2 Indicate earliest date you treated any OWCP beneficiary.
- Block 3 Type or print your practice name.
- Block 4 Type or print your practice street address.
- Block 5 Type or print your practice city.
- Block 6 Type or print your practice state.
- Block 7 Type or print your practice zip code (all nine digits).
- Block 8 Type or print your practice telephone number.
- Block 9 Type or print your practice FAX number (if applicable).
- Block 9a Type or print your practice email address (if applicable).
- Block 10 Check your practice type---"a" for individual practice, "b" for a facility if you are one of the provider types listed (refer to the list of provider type codes below), or "c" for a group practice. Black Lung only: providers should disregard group practice information. If you checked "c" (group practice), fill out the appropriate parts of Block 10c on page two of the form for each professional that will be providing services under the group Provider Number (name, Social Security number, provider type code from list below, license number and State, expiration date of current license, specialty code or codes from the list below, and the date any certification expires). Continue on a separate sheet if necessary.
- Block 11a If you checked "a" or "b" (individual practice or facility) in Block 10, type or print your "Provider Type" code from the list below.
- Block 11b If you checked "a" or "b" (individual practice or facility) in Block 10, type or print the "Provider Type" that corresponds with the code you entered in Block 11a.
- Block 11c If you checked "a" or "b" (individual practice or facility) in Block 10 and selected "Other Provider" (code 96) or "Non-Medical Vendor (code 53), please explain why you are enrolling.
- Block 12 If you checked "a" or "b" (individual practice or facility) in Block 10, type or print your Social Security number and/or your EIN, as appropriate.

**PAYMENT INFORMATION FORM
ACH VENDOR PAYMENT SYSTEM**

This form is used for the ACH payments with an addendum record that carries payment-related information. Recipients of these payments should bring this information to the attention of their financial institution when presenting this form for completion.

PAPERWORK REDUCTION ACT STATEMENT

The information being collected on this form is required under the provision of 31 U.S.C. 3322 and 31 CFR 210. This information will be used by the Treasury Department to transmit payment data by electronic means to vendor's financial institution. Failure to provide the requested information may delay or prevent the receipt of payments through the Automated Clearinghouse Payment System.

MEDICAL PROVIDER INFORMATION

Provider #: 4235391120	
Name:	Hero Healthcare LLC
Address:	231 walls hollow road
	oliver springs, TN, 37840-3410
Contact Person Name:	Sharlyn Young
Telephone Number:	4235391120

AGENCY INFORMATION

Name:	US Department of Labor
Address:	DEEOIC/Energy
	P.O. Box 8304, London, KY 40742-8304
Contact Person Name:	
Telephone Number:	1 (866) 335-8319 Toll Free

FINANCIAL INSTITUTION INFORMATION

Name:	Citizens first bank										
Address:	po box498										
	Oliver Springs, TN, 37840-0498										
ACH Coordinator Name:	Tina Sexton					Telephone Number:	8654356655				
Nine-Digit Routing Transit Number:	0	6	4	2	0	4	4	0	2		
Depositor Account Title:	Sharlyn Young BDA Hero Healthcare										
Depositor Account Number:	[REDACTED]										
Type of Account:	<input checked="" type="checkbox"/> Checking <input type="checkbox"/> Savings										
Signature and Title of Representative:						Telephone Number:					

Provider Enrollment Form

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

CR Number: 11515641



OMB Number 1215-0137
 Expires: 01/31/2010

Please refer to instructions for completing this form.

Provider Number		Effective Date	
FOR DOL USE ONLY			
1. Are you applying for a new enrollment or updating your record? If update, enter Provider Number or EIN:		<input checked="" type="checkbox"/> New enrollment	<input type="checkbox"/> Update
2. What is the earliest date that you treated a participant in any OWCP program?			
Practice Information			
3. Practice Name	Hero Healthcare LLC	4. Address	231 walls hollow road
5. City	oliver springs	6. State	TN
		7. Zip (9 digits)	37840-3410
8. Telephone	4235391120	9. FAX	
10. Type of Practice a. <input checked="" type="checkbox"/> Individual b. <input type="checkbox"/> facility (For Individual or Facility, complete indicated sections below) c. <input type="checkbox"/> Group (Please see reverse for completion of group enrollment)			
Provider Type (Individual or Facility)			
11a. Provider Type Number	37	11b. Provider Type	37- Licensed Practical Nurse (LPN)
11c. If you select "Other Provider" (96) or Non-Medical Vendor (53), please explain:			
12. Tax ID: EIN		SSN	
13. Required for hospitals only:		13a. Medicare Number	
13b. NPI:	1.	13c. Taxonomy Code(s): 1.	
	2.	2.	
	3.	3.	
License and Certification (Individual for M.D. and D.O. only)			
14a. Name	14b. License #/ State	14c. Current Lic Expiration Date	14d. Specialty Code(s)
Hero Healthcare LLC	67663/TN	03/31/2016	
15. Unified Mine Workers' of American (UMWA) Number, if applicable:			
Billing Address-indicate "same" if identical to Practice Address.			
16a. Address same			
16b. City	16c. State	16d. Zip (9 digits)	
17. <input checked="" type="checkbox"/> I have Completed a form for Electronic Funds Transfer (EFT).			
18. <input checked="" type="checkbox"/> I am Interested in billing electronically			
NOTICE: Anyone who misrepresents or falsifies essential information to receive payment from Federal funds may upon conviction be subject to fine and imprisonment under applicable Federal laws.			
Signature (Provider or Representative and Title)		Date	
Sharlyn Grant Sen		06/18/2014	



Department of Labor-OWCP
ELECTRONIC DATA INTERCHANGE



PLEASE INDICATE YOUR CLASSIFICATION:

☐ Software Vender
 ☐ Switch Vender
 ☒ Provider
 ☐ Clearinghouse
 ☐ Billing Agent

A1. Please indicate classification information.			
Submitter/Vendor/Provider Name: <u>Sharilyn Young</u>			
Address: <u>231 Walls Hollow Road</u>			
City, State, Zip: <u>Oliver Springs, TN 37840</u>			
Telephone #: <u>423-539-1120</u>		FAX #: <u></u>	
Provider Number: <u></u>		EIN: <u>34-54343</u>	
Group Provider Number: <u></u>		EMAIL ADDRESS: <u>Hern Healthcare@outlook.com</u>	
Provider Specialty: <u></u>			
A2. Please indicate contact information, if different from Submitter/Vendor/Provider information in Section A1.			
Contact Name and Title: <u></u>			
Business Address: <u></u>			
City, State, Zip: <u></u>			
Phone Number: <u></u>		Fax Number: <u></u>	
Email Address: <u></u>			
A3. If you have indicated that you are a Software Vendor in section A1, please provide the following information:			
Software Name: <u></u>		Software Version: <u></u> Protocol: <u></u>	
Do you currently have clients submitting to ACS? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
A4. Electronic Submission Method			
Submitter Type: <input type="checkbox"/> Vendor Software <input type="checkbox"/> Clearinghouse <input type="checkbox"/> Billing Agent			
Formal Type: <input type="checkbox"/> Proprietary <input type="checkbox"/> X12N			
Transaction Type: <input type="checkbox"/> Professional <input type="checkbox"/> Dental <input type="checkbox"/> Institutional <input checked="" type="checkbox"/> HCFA <input type="checkbox"/> UB			
Submission Method: <input checked="" type="checkbox"/> WEB <input type="checkbox"/> NDM <input type="checkbox"/> ASYNC			
A5. Electronic Report Retrieval			
Are you interested in retrieving your transaction electronically? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
Who will retrieve your reports? <input checked="" type="checkbox"/> You <input type="checkbox"/> Billing Agent <input type="checkbox"/> Clearinghouse			
Which reports would you like to access electronically? <input checked="" type="checkbox"/> Functional Acknowledgement (997) <input checked="" type="checkbox"/> Healthcare Claim Payment Advice (835)			

Please return complete forms via Mail or FAX to: (850) 201-1718
 ACS ENROLLMENT DEPARTMENT
 US Department of Labor
 OWCP
 P.O. Box 8304
 London, KY 40742-8304

(Incomplete forms will cause a delay in processing and are subject to return).

Attachment C Orderly Development Item 5

DCN: 4199900003 Page 3

07/17/2014 THU 9:36 FAX
08/25/2014 12:25 FAX 8854574234

C and D Printing

0003/006
0007/0008

Energy Enrollment
Energy Enrollment
Energy Enrollment

U.S. Department of Labor

Employment Standards Administration

Office of Workers' Compensation Programs

CR Number: 11515641

CR Number: 11515641

OMB Number 1215-0137
Expires: 01/31/2010

Please refer to instructions for completing this form.

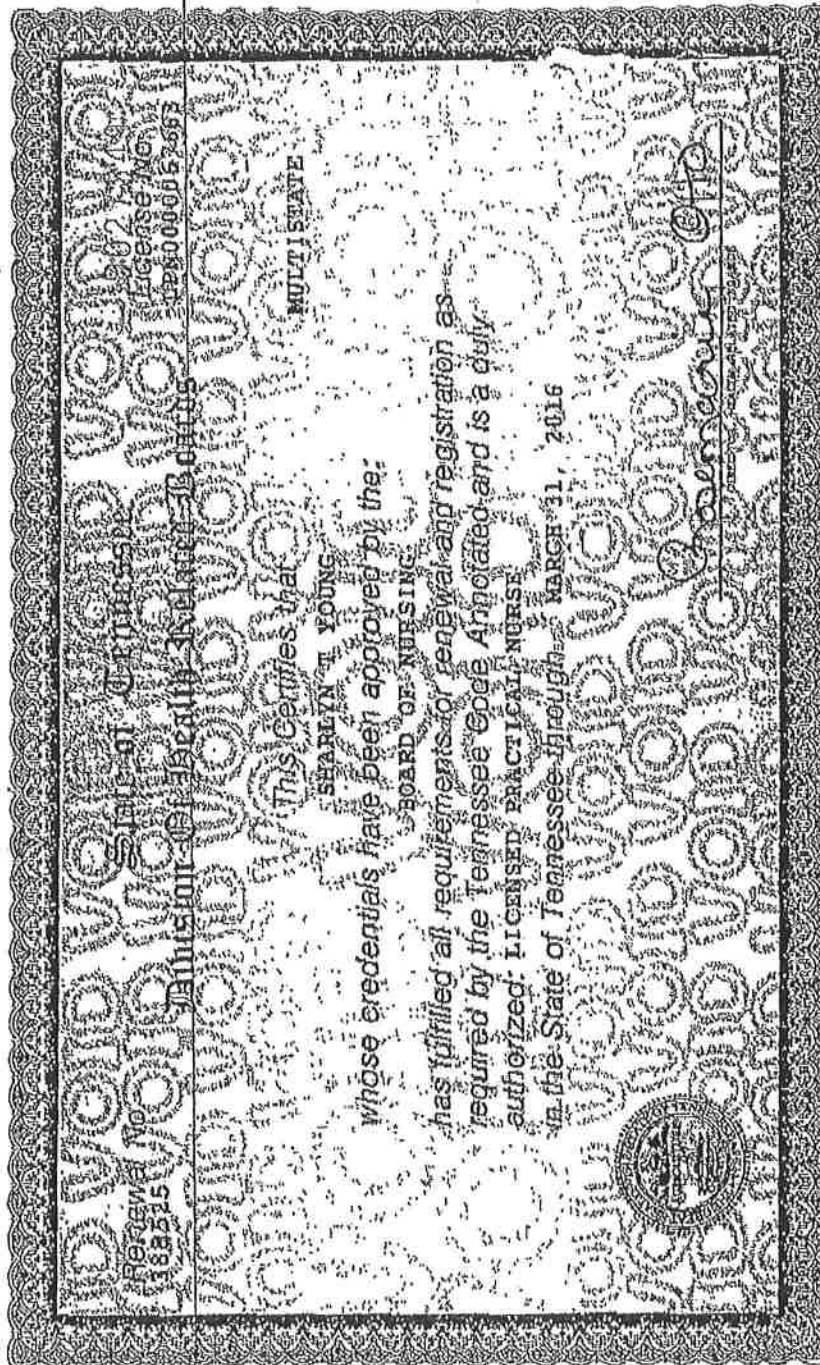
Provider Number		Effective Date	
FOR DOL USE ONLY			
1. Are you applying for a new enrollment or updating your record? If update, enter Provider Number or EIN: <input checked="" type="checkbox"/> New enrollment <input type="checkbox"/> Update			
2. What is the earliest date that you treated a participant in any OWCP program?			
Practice Information			
3. Practice Name		4. Address	
Hero Healthcare LLC		231 walls hollow road	
5. City		6. State	7. Zip (9 digits)
oliver springs		TN	37840-3410
8. Telephone		9. FAX	
4235391120			
10. Type of Practice a. <input checked="" type="checkbox"/> Individual b. <input type="checkbox"/> facility (For Individual or Facility, complete indicated sections below) c. <input type="checkbox"/> Group (Please see reverse for completion of group enrollment)			
Provider Type (Individual or Facility)			
11a. Provider Type Number		11b. Provider Type	
37		37- Licensed Practical Nurse (LPN)	
11c. If you select "Other Provider" (96) or Non-Medical Vendor (53), please explain:			
12. Tax ID: EIN		SSN	
465713713		37 4 1	
13. Required for hospitals only:		13a. Medicare Number	
13b. NPI:		13c. Taxonomy Code(s):	
1.		1.	
2.		2.	
3.		3.	
License and Certification (Individual for M.D. and D.O. only)			
14a. Name		14b. License #/ State	14c. Current Lic Expiration Date
Hero Healthcare LLC		67663/TN	03/31/2016
		14d. Specialty Code(s)	14e. Certification Expiration Date
15. United Mine Workers' of America (UMWA) Number, if applicable:			
Billing Address-Indicate "same" if identical to Practice Address.			
16a. Address		16c. State	
same			
16b. City		16d. Zip (9 digits)	
17. <input checked="" type="checkbox"/> I have Completed a form for Electronic Funds Transfer (EFT).			
18. <input type="checkbox"/> I am interested in billing electronically			
NOTICE: Anyone who misrepresents or falsifies essential information to receive payment from Federal funds may upon conviction be subject to fine and imprisonment under applicable Federal laws.			
Signature (Provider or Representative and Title)		Date	
Sharon Grant, RN		08/18/2014	

DCN: 4177900001 Page 4

06/25/2014 1:13 PM

and Printing

No. 3483 WP. 4/70000



140320

06/25/14

STATE OF TENNESSEE
DIVISION OF HEALTH RELATED BOARDS

EXPIRATION DATE: 03/31/2016
LICENSE NO.: LPN0000007003
RENEWAL NO.: 388525

THIS IS TO CERTIFY THAT
SHARLYN T. YOUNG
IS A DULY LICENSED
LICENSED PRACTICAL NURSE
IN THE STATE OF TENNESSEE AS REQUIRED BY THE
TENNESSEE CODE ANNOTATED.

Barbara C. Ho
DIRECTOR, HEALTH RELATED BOARDS

MULTISTATE

SIGNATURE

United States Department of Labor
Office of Workers' Compensation Programs
Division of Energy Employees Occupational Illness Compensation (DEEOIC)

EEOICP Medical Provider Enrollment

Introduction

Welcome to the Department of Labor EEOICP Medical Provider Enrollment Information page. As of November 17, 2004, the DEEOIC contracted with Affiliated Computer Services (ACS) to handle all medical authorizations and bill processing. On this page you will find the link you need to obtain the necessary forms to enroll as an EEOICP Medical Provider as well as detailed information on the hours of operation.

Medical Provider Enrollment

Qualified Medical Providers are encouraged to enroll in the EEOICP. Please visit the ACS Web Portal for enrollment information at <http://owcp.dol.acs-inc.com>. This link will take you to the forms necessary for enrollment. Enrollment can be completed online or simply printed, completed and mailed in. Once you are enrolled in the EEOICP, you will have access to medical bill status, payment status, enrollment status and medical authorization status.

EEOICP Medical Bill Operations

Telephone: 1-866-272-2682

Hours of Operation: Monday through Friday, 8:00 AM to 8:00 PM (EST.)

Mailing Address for Medical Bills:

Energy Employees Occupational Illness Compensation Program (EEOICPA)

P.O. Box 8304

London, Kentucky 40742-8304

Mailing Address for Enrollment Forms:

EEOICP Enrollment Unit

P.O. Box 8304

London, KY 40742-8304

(888) 444-5335 (fax)

Medical Bill Provider Enrollment Documents:

- Provider Enrollment Form and Instructions
- Helpful Hints for Billing
- EFT (ACH) Vendor Payment Form and Instructions
- EDI Enrollment Form
- Department of Labor Trading Partner Agreement

ACS Web Bill Processing Portal Office of Workers' Compensation Programs

[Home](#) | [ACS Contact Info](#) | [Portal FAQ](#) | [Forms & Links](#) | [FECA & DEEOIC Fee Schedule](#)

[HELP](#)

[Table Of Contents](#)

Provider Enrollment Application

Reference #: KTKU82VFBA

[Participation Agreement](#)

Instructions

[Instructions](#)

Your Reference Number is: **KTKU82VFBA**

[Help](#)

Please record your reference number. Your reference number is only used during the process of filling out the application or to recall the application at a later time. Once you complete the application you will receive a CR (Correspondence Record) number, which you can use it for tracking the status of the application.

[Enrollment FAQs](#)

[Enrollment Contacts](#)

- This Reference Number is only valid for 30 days, please complete this process within this timeframe.
- If you fail to complete this process within 30 days, you must submit a new online enrollment application.

Provider Enrollment Application Instructions

- Complete all areas of the application, unless otherwise indicated.
- After completing your application, follow the steps under Submit Application to validate your application and review a draft PDF of your application.
- Any additional information entered on your web-based application that exceeds the standard space allotted in the Provider Enrollment form will be added to the end of the PDF application.
- Print and retain a copy of the completed application for your records. Submit any additional required documents to the below addresses :

US Department of Labor
OWCP/FECA
P.O. Box 8300
London, KY 40742-8300

US Department of Labor
DEEOIC/Energy
P.O. Box 8304
London, KY 40742-8304

US Department of Labor
DCMWC/Black Lung
P.O. Box 8302
London, KY 40742-8302

This application will not be accepted if any portion has been filled out incorrectly, or if forms are not completed or missing.

Contact Customer Service Agent

You may contact a Provider Enrollment Specialist by calling (844) 493-1966 for any questions concerning this application.

Saving an Application for Recall at a Later Time

If at any time while completing this application you would like to save your information and finish at a later time, click the Save Application button at the bottom of the page. The next time you visit the online application, enter your reference number in the Recall Application section.

Thank you for your interest in supporting the DOL-OWCP Program.

[Continue](#)

Visit the following websites for additional information on OWCP programs:

[DOL Home](#) | [OWCP Home](#) | [FECA Home](#) | [DCMWC Home](#) | [DEEOIC Home](#)

[Online Security](#) | [Browser Compatibility](#) | [Terms of Usage](#)



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SUPPLEMENTAL

Provider Enrollment FAQ

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19. How do I check the status of my Online or Paper enrollment?
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21. Am I required to complete the Web Registration in order to enroll using this system?
22. What information is available once I register for the Web Portal?

1. What is Provider Enrollment?

a. Provider enrollment is the process in which you will receive your 9-digit ACS provider number for filing bills for services rendered to DOL claimants. To enroll with Department of Labor, Office of Workers' Compensation (OWCP) programs FECA, Black Lung and Energy, a provider must complete and submit the Provider Enrollment application. The enrollment is complete once all applicable fields on the application are filled in correctly (practice name, practice address and phone number to the practice physical location, Tax ID number, valid license/certifications attached, copy of Medicare and NPI numbers attached-required for hospitals, EFT applications with voided check attached-required for Black Lung and Energy and all applications must be signed).

[Top](#)**2. Who can enroll using the DOL Online Provider Enrollment Process?**

a. Providers who are enrolling for the first time can do so via the DOL Web portal. Enrollment Applications for the FECA, Black Lung and/or Energy programs can be submitted using this online resource.

[Top](#)**3. How do I update my current enrollment information?**

Providers who have an active ACS provider number can update provider information by submitting a hard copy of the Provider Enrollment Application. Please use the provider enrollment application if you are changing your practice name, have a new Tax ID# or need to add new provider (s) to an existing group. You can download a hardcopy of the provider enrollment application via the DOL Web portal @<http://owcp.dol.acs-inc.com>. The application can be found by clicking the 'Forms & Links' option on the web portal's main page.

[Top](#)**4. How can I change my address, add/update EFT banking account information or enroll to with EDI (Electronic Data Interchange)?**

a. Providers can change their address, add/change EFT account information or enroll with EDI by submitting the proper form. The Change of address form, EFT application (submit with a voided check attached) or EDI enrollment form are to be submitted to the ACS Provider Enrollment Department. Please use the change of address form to notify ACS if your practice physical address, correspondence or remit address has changed. The EFT application is used when a provider wants to receive funds electronically or to change banking information on an existing account

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(EFT is mandatory for Black Lung and Energy programs). If you are a provider who wishes to submit claims through a billing agent, clearinghouse, or you are using vendor software, please complete and submit the EDI enrollment form. You can download a hardcopy of the forms via the DOL Web portal @<http://owcp.dol.acs-inc.com>. The forms are found by clicking the 'Forms & Links' option on the DOL Web portal's main page.

[Top](#)**5. How do I add additional individuals to my DOL Provider number?**

a. To 'Add new member to an existing group' download a hardcopy of the application, complete all required information then mail to one of the addresses below in FAQ 8 or fax to 888-444-5335 the Provider Enrollment Department. The application may be found by clicking the 'Forms & Links' option on the DOL Web portal @<http://owcp.dol.acs-inc.com>. Remember to include all required documents along with the application to avoid delays. (Update online feature is pending)

[Top](#)**6. Can I fax my application for processing?**

a. YES. If you wish, you can download a hardcopy of the application via the DOL Web portal @ <http://owcp.dol.acs-inc.com>. The application may be found by clicking the 'Forms & Links' option on the web portal's main page. Once the application is complete, you can fax to the Provider Enrollment dept @ 888-444-5335. Remember to include all required documents along with the application to avoid delays. The instructions on how to bill using the OWCP-1500, UB-04, UD-04 (Dental) and NCPDP (Pharmacy), Medical authorization forms, change of address form, EFT application as well as the EDI forms can be found at this link. If you are a provider enrolling for the first time, DOL online enrollment process is also available.

[Top](#)**7. How long does it take to process an enrollment application completed online?**

a. The enrollment application process takes five (5) business days of receipt of a correctly completed application. Incomplete applications are returned for required information. Incomplete enrollment applications will be returned to the provider via mail outlining the specific reason why the application was return and what is needed to complete the application process. To avoid delays, please ensure that the application is complete and all required forms and/or attachments are submitted. See FAQ number 1 for explanation of a completed Enrollment Application.

[Top](#)**8. How do I contact the Provider Enrollment department for enrollment assistance?**

FECA Enrollment
ACS Enrollment Unit
Department of Labor
PO Box 14600
Tallahassee FL 32317-4600
FECA Ph #: 844-493-1966
FECA Fax #: 888-444-5335

DEEOIC Enrollment
EEOICP Enrollment Unit
PO Box 13400
Tallahassee FL 32317-3400
DEEOIC Ph #: 866-272-2682
DEEOIC Fax #: 888-444-5335

DCMWC Enrollment
DOL DCMWC Enrollment Unit
PO Box 13200
Tallahassee FL 32317-3200
DCMWC Ph #: 800-638-7072
DCMWC Fax #: 888-444-5335

[Top](#)**9. The services that I provide are not listed.**

a. You should select Provider Type: 96- other and provide an explanation of the services provided in the resulting 'Explanation' field. Additional analysis will be performed on your provider type to ensure the correct provider type is assigned.

[Top](#)**10. Can each practitioner at our location enroll using the Practice's Tax ID; yet receive their own DOL Provider number?**

a. NO. Only one (1) DOL provider number may be assigned for all individual providing services at that location. Therefore the practice should be enrolled as a Group with each practitioner being associated with the Group's Provider number. However, if you need to enroll under this tax ID/EIN/SSN an explanation must be provided and a

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paper enrollment submission will be required via fax for the appropriate OWCP program. Currently Provider Enrollment does not issue multiple provider numbers to members in a group unless they are in a different location.

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11. Why must I enroll using an EIN when enrolling my Group and not my SSN (social security number)?

a. A group practice is required to use an EIN (Federal Tax ID #) when enrolling. Therefore may not enroll using an individual's SSN. If you are an individual enrolling as an individual and don't have a Tax ID/EIN the SSN maybe used.

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12. Why am I required to enter license information for my medical group/practice?

a. The license documentation (i.e., State License (s), Board Certification (s), and other medical certification (s)) is required stating that the practice, facility and/or individual group members are legally sanctioned to render services requested on the enrollment application.
b. For online enrollment, a copy of State License (s), Board Certification (s), and other medical certification (s) can also be uploaded, mailed (to one of the addresses in FAQ8) or faxed (888-444-5335) into the Provider Enrollment Department to complete the enrollment process.

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13. My license expires in 30 days can I still enroll?

a. YES. The system will initially accept the license/ certification that expires within 30 days, however the Provider will need to obtain more current information for submission to provider enrollment to avoid enrollment processing or bill payment delays.

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14. Why isn't my billing office's information accepted within the Practice Information fields?

a. To ensure proper processing of all information, only the physical address and phone number where services are being rendered may be entered in these fields. You may include all billing information within the Billing Address and phone number fields for proper routing. No PO Boxes will be accepted as the physical address.

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15. Personnel are not always available to answer calls at the phone number where services are rendered. Am I still required to enter the phone number to the physical address?

a. YES. The phone number where services are rendered will be verified to ensure that it coincides with the physical address entered. If the phone number to your billing office is entered for the phone number of physical location, it will only delay the enrollment process and/or require that the application be returned.

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16. Am I required to enroll in Electronic Funds Transfer (EFT) or Electronic Remittance Voucher (RV)?

a. Enrollment in EFT is required for the DCMWC and DEEOIC programs and therefore optional if enrolling in the FECA program only.
b. Enrollment in Electronic Remittance Voucher (RV) is Optional for all programs

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17. I have submitted my online enrollment application, yet I didn't receive a DOL Provider Number. Why?

a. Upon review and receipt of all required information by the Provider Enrollment department, a paper welcome letter will be mailed within 5 business days notifying you of your DOL Provider Number. The welcome packets are forwarded to the correspondence address as indicated on the provider enrollment application. If no other address is indicated, then the welcome packet will be forwarded to the provider's physical address.

[Top](#)**18. I have submitted my Paper enrollment application, yet I didn't receive a DOL Provider Number. Why?**

a. Upon review and receipt of all required information by the Provider Enrollment department, a paper welcome letter will be mailed within 5 business days notifying you of your DOL Provider Number. The welcome packet is forwarded to the correspondence address as indicated on the provider enrollment application of box 16a, 16b, 16c and 16d. If no other address is indicated in boxes 16a thru 16d, then the welcome packet will be forwarded to the provider's physical address.

[Top](#)**19. How do I check the status of my Online or Paper enrollment?**

a. You may check the status of your application by clicking on the "Provider Enrollment Status Inquiry" option on the DOL Web portal @ <http://owcp.dol.acs-inc.com> and entering the required information. The resulting screen will display your application status or indicate that no matching records were found. If no record is found then the application is still in process. You can also check the status using the IVR phone system @ 1-866-335-8319 or speak with an Enrollment Call Center @ 1-(844) 493-1966 Option 4 Option 2.

[Top](#)**20. Is the Tax ID/EIN/SSN the same as my DOL Provider Number?**

a. NO. The provider number is NOT your Federal Tax ID/EIN/ SSN; it is a 9-digit number assigned to you by ACS the fiscal agent for the Department of Labor. If you are not sure what your Provider Number is, you can call Customer Service @ (844) 493-1966 and speak to a customer service agent or use the IVR phone system @ 1-866-335-8319. The provider number can also be found on any Remittance Voucher (RV) you receive. It will be located on the top right of the report and will appear as Provider ID: xxxxxx-xx (where 'x' is a numeric value).

[Top](#)**21. Am I required to complete the Web Registration in order to enroll using this system?**

a. NO. Registration is not required in order to complete the enrollment process. Once you receive your ACS provider number, web registration is the process in which a provider can register their ACS 9 digit provider number to access online information. For your convenience, you can register your provider number via the DOL Web portal @ <http://owcp.dol.acs-inc.com> by clicking on any of the program links FECA, Black Lung (DCMWC) or Energy (DEEOIC). Once you click on one of the program links, this will take you to the DOL agreement page. On this page there is a panel on the left side of the screen that will display the Web Registration link. Click the link to display the page to register your ACS provider number. You can also contact the Web Portal Help Desk @ 1-800-461-7485. Once the Web registration is complete, a temporary password will be emailed to the email address provided.

[Top](#)**22. What information is available once I register for the Web Portal?**

a. The following information is available once the Web Registration process is complete: Provider Enrollment Status Inquiry, Claimant Eligibility Inquiry, Bill Status Inquiry, Medical Authorization Inquiry, Payment Status Inquiry, Change Password, Entry of Medical Authorizations (FECA & DEEOIC programs).